University of Alberta

The Counselling Experiences of Formerly Suicidal Adolescents

by

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DEDICATION

To my father

Jerzy Domanski (1949-2003)

for teaching me about perseverance

ABSTRACT

A wide body of research exists on etiological and epidemiological factors involved in adolescent suicide, with the intent of aiding suicide prevention efforts by identifying risk factors and vulnerable populations. However, psychological treatment of suicidal ideation and behaviour in adolescence is relatively unexplored in the extant literature. Furthermore, current treatment approaches focus largely on crisis intervention rather than the resolution of problems underlying suicidality. The present study sought to explore the counselling experiences of formerly suicidal adolescents in order to help inform counsellors' work with suicidal teenagers. Using the methods of hermeneutic phenomenology, five themes were identified in participants' accounts: Appreciating Counsellor Openness, Needing Direction, Feeling Unattended to as an Individual, Yearning for a Relational Climate, and Wishing that Counsellors Would "Reroute" the Topic of Suicidality. Furthermore, paradigm cases in the participants' accounts were used to illuminate additional salient features of their counselling experiences: Feeling Expendable due to lack of continuity in counselling and Feeling Mute due to lack of a heard voice in counselling. These aspects may have contributed to a sense of disempowerment for the participants. Based on a synthesis of the above findings, the common thread in participants' experiences of counselling following suicidality in adolescence was Seeking Empowerment Through Connection. Implications of these findings for counselling practice, administration, and future research are discussed.

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CHAPTER 1: INTRODUCTION

Adolescent Suicide in Society

The phenomenon of suicide is perplexing, bewildering, or even overwhelming to most people; comprehending it is a complex endeavour (Leenaars, 2004). Suicide is all the more troubling when it occurs in adolescence, because it may be difficult to understand why a teenager – young and full of potential – would choose to not live. Furthermore, our society holds many religious prohibitions against taking one's own life. It is not surprising that the topic of adolescent suicide is taboo and largely denied within our culture (Popenhagen & Qualley, 1998; Berman, Jobes, & Martin, 2005).

The taboo nature of adolescent suicide contributes to society's incomplete and often inaccurate knowledge of this subject by limiting open discussion, thus hindering understanding. In general, popular culture only compounds the problem by displaying and reinforcing myths about suicide. For instance, in the eyes of adolescents, the cult status of entertainers such as Kurt Cobain who committed suicide at a young age may portray suicide as glamorous or even enviable, and Shakespeare's depiction of Romeo and Juliet as star-crossed lovers who took their own lives may romanticize suicide. In many adults' eyes, however, such displays of suicidality in young people may instead characterize their behaviours as attention seeking or impetuous. Not only is each of these perceptions of adolescent suicide an oversimplification or a blatant untruth, but the polarity in the perceptions may also add to confusion and discomfort around this subject. Due to such factors, the public is unenlightened regarding the realities and complexities of youth suicide, in parallel with society's ignorance about suicide in general (Pompili, Tatarelli, & Lester, 2005).

However, adolescent suicide impacts heavily on society. Most directly, it changes irrevocably the lives of the deceased individual's loved ones who must learn to survive in the face of their loss. News of an adolescent's suicide attempt or death by suicide may also evoke strong reactions in other persons (e.g., Lester, 2005) as they struggle to understand and accept the event. Furthermore, non-fatal suicidal behaviours that begin at a young age can have life-long negative repercussions, and therefore, such behaviours should be attended to promptly and vigorously by the mental health system (Rhodes & Links, 1998).

Unfortunately, Canada's adolescent suicide rate has increased dramatically since the middle of the 20th century (Sakinofsky & Leenaars, 1997). In 1960, the annual suicide rate per 100,000 people in the 15- to 19-years-old age group, averaged for both genders, was 3.25 (Leenaars & Lester, 1990). By 2003, this figure had more than tripled to 10.2; translated into tangible numbers, a total of 216 Canadians aged 15 to 19 committed suicide in that year alone (Statistics Canada, 2006).

While increases in the adolescent suicide rate have also occurred in many other countries (Lester, 1990), the particular problem of the youth suicide rate in Canada was highlighted in a 1994 United Nations report which found that Canadian 15- to 19-year-olds ranked third highest in suicide rates out of 23 countries (Cutcliffe, 2005). In addition, the rate of attempted suicide, which is not tracked formally, is estimated to be many times that of completed suicides, particularly in adolescent females (Langlois & Morrison, 2002), indicating that the vast majority of suicide attempts do not end in death; nevertheless, they still usually reflect psychological distress. Thus, taking into account the adolescents who complete suicide and those

who contemplate or attempt suicide but do not die, as well as these individuals' families and friends, it becomes clear that the lives of a great many people are impacted by adolescent suicidality each year.

A large body of research on various aspects of this significant problem exists. However, effective psychotherapeutic methods aimed at the treatment of suicidality remain elusive, particularly in the adolescent population. The literature on adolescent suicidality mainly addresses issues of prediction and crisis intervention (Everall & Paulson, 2001); treatment of suicidality in adolescents and the effectiveness of such treatment remain neglected areas of research. Overall, the existing research has not addressed the mental health treatment of suicidal adolescents in a meaningful way, and thus, knowledge of effective (or ineffective) approaches to working with suicidal adolescents is limited.

Researchers have only recently started to rectify this problem. Because much of this new research is exploratory, the methods utilized have often been qualitative. There has been an emphasis over the last decade on studying the phenomenology of being suicidal (Berman, Jobes, & Silverman, 2006) and such approaches are being extended to the study of treatments for suicidality. For instance, Paulson and Everall (2003) examined suicidal adolescents' perceptions of helpfulness in counselling, building on Paulson and Worth's (2002) similar study with suicidal adults. Their findings illuminated important aspects of working with suicidal people and have set the stage for further research of suicidal individuals' subjective experiences in counselling. While these two studies focused specifically on aspects of counselling felt by clients to be helpful, I believe that it is important to also examine suicidal

persons' counselling experiences in their entirety, including any unhelpful aspects and facets potentially not encapsulated by the construct of helpfulness, in order to more thoroughly explore these counselling experiences and to uncover elements which may have remained hidden in previous research.

The following chapters describe my study of experiences of counselling following suicidality in adolescence. The research is exploratory in nature because few prior findings have been reported on this topic and none have addressed aspects of such counselling other than its helpfulness. A qualitative research paradigm was utilized in this study, as the aim of such an approach is to generate a core description of experience (Polkinghorne, 2005) in order to uncover its significance and meaning (Banister, Burman, Parker, Taylor, & Tindall, 1994), and these knowledge outcomes in relation to suicidal teenagers' counselling experiences are lacking in the current literature.

Purpose of the Study

In this study, my goal is to explore experiences of counselling following suicidality in adolescence in an in-depth manner. The main purpose is to facilitate understanding of adolescent clients' perceptions of counselling related to suicidality and to cultivate an appreciation of these clients' counselling needs. Moreover, I hope to conceptualize this knowledge in ways that will assist the development of effective treatments of adolescent suicidality.

The goal of mental health treatment of suicidal individuals is presumably the cessation of suicidal ideation and behaviours, and a return to "normal" functioning. However, the processes via which counselling interventions may facilitate this goal –

or conversely, impede it – as well as clients' experiences of such processes, are still largely unclear. Knowledge of these factors would benefit counsellors working with suicidal people by bringing awareness to the necessary or principal components of psychotherapeutic work in this area, potentially allowing more effective and efficient treatment. The current study involved conducting detailed interviews with individuals who had experienced counselling following adolescent suicidality, and carrying out a qualitative analysis of the participants' described experiences. This approach strives to discover what suicidal adolescents themselves found to be – as well as not to be – meaningful, important, and helpful in counselling. By giving a voice to individuals who experienced counselling in relation to suicidality in adolescence, some of the gaps in the current literature on the treatment of adolescent suicidality may be filled.

Organization of the Document

In the present chapter, I provide an introduction the topic of adolescent suicidality and to this study. In the next chapter, a review of the research literature that addresses relevant aspects of the research topic, including the existing treatment approaches to working with suicidal adolescents, articulates the current state of knowledge. The method used in this study to explore experiences of counselling following suicidality in adolescence is described in the subsequent chapter. Readers are then familiarized with the research participants via a presentation of their stories, and the results of the analysis are portrayed. A discussion of the correspondence of the findings to the research literature and their implications for counselling practice, administration, and further research rounds out the document.

CHAPTER 2: REVIEW OF THE LITERATURE

In this chapter, I discuss the current understanding of adolescent suicidality, the multiple risk and protective factors known to be involved, and various issues concerning the mental health treatment of suicidal adolescents. The significance of the present study is elucidated in the context of the current research knowledge and the gaps therein. The evolution of my research topic is then described, culminating in the research question. First, however, are some definitions relevant to the topic of adolescent suicidality.

Definitions

The study of suicidality necessitates a definition of relevant terms. Although some confusion exists in the literature concerning terminology – for instance, there is a lack of consensus regarding the exact definitions of, and distinctions among, the commonly used terms "suicide attempt," "suicide gesture," "parasuicide," and "self-harm" (Bland, Dyck, Newman, & Orn, 1998; King, 1997; O'Carroll et al., 1996) – the following are the definitions utilized in the present study:

- Suicide: a conscious act of self-induced annihilation (Shneidman, 1985)
- Attempted suicide or suicide attempt: self-injurious behaviour with a nonfatal outcome and with evidence (either explicit or implicit) that there was intent to die (American Psychiatric Association, 2003); distinct from deliberate self-harming behaviours which are not intended to result in death
- Suicidal ideation: thoughts of committing suicide, which may include a specific behavioural plan to do so; arguably precedes any act of attempted or completed suicide (Hughes & Neimeyer, 1990)

- Suicidality: the spectrum of suicidal phenomena, including ideation, attempts, and completed suicide
- Adolescence: the time period between childhood and adulthood; defined as the teenage years (13 through 19) in the present study

The Continuum of Suicidal Phenomena

Suicidal ideation, attempts, and completions exist on a severity continuum (Brent, Perper, et al., 1988; King, 1997), although the temporal progression through the three phases of this continuum may not be the same for all individuals (Kienhorst, De Wilde, & Diekstra, 1994). As King points out, aspects of the different phases of suicidality may overlap; therefore, adolescents in the different phases share many characteristics. For instance, Kosky, Silburn, and Zubrick (1990) have shown that few differences exist between youths who think about suicide and those who attempt it, with the exception of prevalence: suicidal ideation is common in adolescence, while suicide attempts are less so (Gutierrez, Muehlenkamp, Konick, & Osman, 2005), although adolescents still have a higher prevalence of suicide attempts than any other age group (King, 1997). Furthermore, many similarities are found between people who attempt suicide and those who complete it (Brevard, Lester, & Yang, 1990; Tiller et al., 1998), although the two groups are seen by some (e.g., Moskos, Achilles, & Gray, 2004) as largely distinct, due to differences such as greater likelihood of psychopathology in adolescents who complete suicide (Schaffer & Pfeffer, 2001).

One typical difference between adolescents who attempt suicide and those who complete it is gender. Analyses consistently show that female adolescents' mortality rate from suicide is 3 to 5 times lower than that of their male counterparts,

but that their rate of attempted suicide is believed to be several times higher, which may be due to the generally less lethal means of suicide used by girls as compared to boys (Joseph, Reznick, & Mester, 2003). Also, adolescent males' greater mortality from suicide may also be influenced by their greater likelihood of being intoxicated and thus disinhibited or showing poorer judgment at the time of a suicide attempt (Groves & Sher, 2005; Sher, Kandel, & Merrick, 2006). Moreover, trends over time in suicide attempt rates in adolescence do not always parallel trends in rates of completed adolescent suicide, which may be due to other differentiating factors between those who attempt and those who complete suicide (Joe & Marcus, 2003).

Likewise, a complicating factor in suicidality research is the often unclear demarcation between suicide attempts and deliberate self-harming behaviours which are not intended to result in death. Lowenstein (2005) notes that many adolescents engage in both self-harm and suicide attempts and therefore it may be a challenge to disentangle the two behaviours. Nevertheless, Muehlenkamp and Gutierrez (2004) discovered in a community sample of adolescents that self-harming behaviours are distinct from suicide attempts based on the given individual's attitudes toward life and death. While self-harming behaviours may unwittingly result in serious injury or death, thus mimicking suicidal acts, elicitation by the researcher or clinician of the subjective meaning of self-injurious behaviours seems justified in order to clarify the adolescent's intent whenever possible and to inform intervention where appropriate.

The Problem of Adolescent Suicide

Current North American rates of adolescent suicide are significantly higher than rates in 1960 (Sakinofsky & Leenaars, 1997), so much so that Zalsman and

Mann (2005), among others, have called adolescent suicide a major public health concern. An erudite discussion of the causes of this trend is beyond the scope of this document. While some have blamed the increase in teenage alcohol abuse and the greater availability of guns in homes (Sher & Zalsman, 2005) or an improved quality of life for adolescents which leads them to believe that they only have themselves to blame for any problems (Lester, 2003), adolescent suicide is multi-determined and thus its influences are complex. Regardless of the reasons for the increase in its rates, however, the statistics are sobering and warrant closer inspection.

Adolescent suicide in North America is a serious problem; in the United States, suicide is the third leading cause of death among teenagers (Groves & Sher, 2005). Perhaps unexpectedly, Canada's adolescent suicide rate is even higher than that of the United States (Leenaars & Lester, 1994). Breton et al. (2002) note that in the second half of the 20th century, the suicide rate among Canadians aged 15 to 19 showed a faster climb than that of any other age demographic, and that by the end of the 1980s, suicide became this group's second leading cause of death. In 2003 (the last year for which statistics were available as of December 2006), 161 males and 55 females aged 15 to 19 committed suicide; additionally, 19 boys and 8 girls between the ages of 10 and 14 took their own lives (Statistics Canada, 2006), for a total of 243 suicides in one year in Canadians aged 10 to 19.

Certain subpopulations in Canada are overrepresented in the overall rates; for example, First Nations adolescents in some regions of the country have a particularly high suicide rate (Gartrell, Jarvis, & Derksen, 1993). Cutcliffe (2005) reports that young First Nations men in particular tend to have elevated suicide rates, especially

within certain northern or rural populations. In addition, young males as a group, regardless of ethnic background, show increased suicide rates within specific regions of Canada, for instance the province of Alberta (Cutcliffe, 2003). On the other hand, as previously mentioned, adolescent females in Canada have a comparatively high rate of suicide attempts (Langlois & Morrison, 2002), but this is not captured by suicide rates which track only completions. Based on the above, it is not surprising that Leenaars and Lester (1990) have referred to Canadian adolescent suicidality as a "relative crisis" (p. 869).

It should be noted that the historical rise in international adolescent suicide rates has been tempered somewhat in recent decades (Lester, 2003). In fact, Brent (2005) states that while the adolescent suicide rate in the United States started climbing steadily in the 1950s, it stabilized and then began declining in the early 1990s, which may have been due to a drop in suicides by means of firearms (Webster, Vernick, Zeoli, & Manganello, 2004) or possibly better detection of depression and suicidality along with provision of treatment (Brent, 2004), such as the widespread use of antidepressant medications in youth (Olfson, Shaffer, Marcus, & Greenberg, 2003). It is not clear if a similar decrease in the teenage suicide rate has occurred contemporaneously in Canada.

Based on outcomes, adolescent suicide is an issue of serious concern for society, which must deal with the social costs of the deaths, and for mental health professionals, who may be called upon to help the bereaved and to implement prevention and treatment programs. Additional concerns arise due to the fact that most people who attempt suicide do not die; research has shown that for each person

who has completed suicide, there may be at least 50-200 people who have made suicide attempts (Orbach & Bar-Joseph, 1993), and that the attempt to completion ratio is even higher in adolescence than in adulthood (Safer, 1997a), particularly for females (Langlois & Morrison, 2002).

A review of studies on adolescent suicide attempt rates from several countries revealed that up to 10% of youth acknowledge having attempted suicide (Safer, 1997b). Interestingly, while the adolescent suicide completion rate in the United States started to fall in the 1990s, the rate of suicide attempts in this age group actually increased slightly between 1991 and 2001 (Joe & Marcus, 2003). Suicidal behaviour which does not end in death is particularly prevalent among females; in Canada, females' hospitalization rate for suicide attempts peaks at ages 15 to 19 and is over twice the rate of males in the same age group (Langlois & Morrison, 2002). While individuals who attempt suicide are likely in distress and thus need assistance, many of them neither disclose their behaviours nor receive help (Rubenstein, Halton, Kasten, Rubin, & Stechler, 1998). It follows that the psychological needs of suicidal adolescents as a group are not getting met appropriately. It seems imperative for mental health professionals working with these individuals to understand adolescent suicidality and to be able to provide effective interventions.

Developmental Factors in Adolescence

Issues that are specific to adolescence may impact the etiology of suicidality in this age group. First, it must be noted that adolescence itself is a fairly recent sociological concept, which did not exist prior to the industrial revolution, and still does not in some societies today (Gonsiorek, 1988). Adolescence fills the temporal

gap between childhood and adulthood, and its age range is somewhat fluid; while it starts with puberty and encompasses the teenage years, it is also often considered to extend past the age of legal adulthood and into the 20s. This prolongation of the socially dependent adolescent phase has coincided with a biological trend toward earlier sexual maturation (Kienhorst, De Wilde, Diekstra, & Wolters, 1995), leading to a scenario in which individuals who are physically adults are still considered to be children. Gonsiorek further notes that our society typically takes a negative view of adolescents, as they are seen to be immature and incapable of adult decision making; according to one of Crook's (2003) young participants, "(t)here's such a prejudice against teenagers, like they mean trouble" (p. 54). Therefore, the sociocultural phenomenon of adolescence itself may present much conflict and confusion to those who are in its midst.

Secondly, the developmental tasks of adolescence may play a role in suicidality. These tasks, as conceptualized by Erikson (1968), are the achievement of identity in the early teen years and the achievement of intimacy in the late teen and early adult years. Identity results in a stable and mature self-concept; intimacy involves establishing a meaningful relationship with another person (Stillion & McDowell, 1996). Lack of successful completion of either of these developmental tasks may predispose an adolescent to suicidality; for instance, adolescents who are experiencing an identity crisis, in which they have not yet made a clear commitment to an identity, show lower levels of psychological well-being than do adolescents who are highly committed to an identity (Meeus, 1996).

Furthermore, cognitive development itself may be a factor in susceptibility to suicidality in adolescence. Two significant determinants of adolescent behaviour are egocentrism, which leads to an inability to distinguish between perceptions of an event and the event itself, and narcissism, which leads to feelings of self-centered grandiosity (Mitchell, 1992). These two factors are likely to effect an inaccurate or exaggerated view of life problems. A concomitant cognitive construction in adolescence is the personal fable, the belief that one is different from others and unique (Elkind, 1981), which may result in disillusionment, alienation, and loneliness (Everall, Bostik, & Paulson, 2005). Alone or in combination, these various cognitive constructions may lead adolescents to have a distorted or romanticized view of suicide and its consequences.

Theoretical Conceptualizations of Suicide

The diversity in the conceptualizations of suicide by key researchers in this field reveals the complexity in understanding this phenomenon. For instance, Ronald Maris' biopsychosocial view of suicide (Maris, Berman, & Silverman, 2000) posits that virtually all suicidal individuals have relevant multidimensional life histories – and not just acute stressors – that have made them vulnerable to suicidality. Antoon Leenaars (1997) conceptualizes suicide as "an intrapsychic drama on an interpersonal stage" (pp. 21-22). Edwin Shneidman (1993) characterizes mental pain, or psychache, as the single psychological mechanism underlying suicide; this mental pain, which results from thwarted psychological needs, is intolerable and serves as the common stimulus for suicide. Furthermore, two dimensions of personality functioning are seen as related to suicidality: perturbation (a subjective feeling of distress) and lethality

(the degree of risk of self-injury) (Shneidman, 1985); both perturbation and lethality are considered important factors in the prediction and assessment of an individual's suicide risk.

Other conceptualizations of suicide abound. In psychoanalytic theories, self-destructive tendencies are the consequence of unconscious death wishes resulting from anger turned inward (Henry, Stephenson, Fryer Hanson, & Hargett, 1994). The cognitive theory of Aaron Beck associates suicidal intent with depression through the construct of hopelessness (e.g., Beck, Brown, Berchick, Stewart, & Steer, 1990). Theories within social psychology emphasize the identification of situational factors such as family variables or environmental changes that may be related to suicidality (Henry et al., 1994); for instance, according to social learning theory, suicidal teenagers may be imitating the suicidal behaviours of family members or friends. Pfeffer's (1996) stress-diathesis model proposes that suicidality is the outcome of interactions between psychopathological factors and adverse life events; in other words, suicidality may be triggered in vulnerable individuals following stressful experiences. This model may help to explain the common observation that adolescent suicidal behaviour often occurs following a "minor" interpersonal crisis, such as an argument with a parent or a boy/girlfriend.

According to Huffine's (1991) review of sociological perspectives on suicide, Emile Durkheim viewed suicide as the result of the extremes of two social processes: integration (the extent to which members of a society are bound together in social relationships) and regulation (the degree to which the desires and behaviours of the members are controlled by societal norms and customs). An excess or a lack of each

process in a society can constitute a suicide risk for its members; for example, weak social integration combined with isolation can lead to the type of suicide commonly associated with adolescent suicide in North American culture.

On the whole, the existing psychological theories of suicidality are quite multifaceted and focus on different aspects of suicidality; for instance, psychiatric theories tend to focus on the biological basis of suicidality, in contrast to psychosocial theories, which focus on the interaction between the individual and the environment. As a result, counsellors may wish to explore such diverse factors as the client's level of perturbation and lethality, frustrated psychological needs, intensity of depression or hopelessness, comorbid psychopathology, environmental and family issues, degree of social integration, and recent acute stressors.

However, these factors have differential significance to different clients, which is unknown at the outset of any given client contact. Furthermore, given the urgency of providing intervention to an individual who is at risk of suicide, which may lead to counsellors' felt pressure of having to "do something" (Crook, 2003, p. 11), the luxury of ample time to thoroughly explore all of these factors may not exist. Although multiple conceptualizations of suicidality may create multiple opportunities to intervene, it is difficult to know which approach should be utilized first (Cutcliffe, personal communication, January 9, 2007) or how to implement an eclectic approach. As a result, there is potential for considerable ambiguity in regard to the mental health treatment of suicidal persons, which may lead counsellors to feel anxiety or distress. This in turn may diminish their ability to intervene effectively.

The preceding overview of various conceptualizations of suicidality highlights the fact that this phenomenon can be viewed from diverse theoretical perspectives. Regardless of theoretical views, however, suicidality is influenced by a multitude of different variables that must be addressed during treatment (McKeown et al., 1998), many of which are explicated in the forthcoming sections addressing risk factors. Unfortunately, knowledge of these variables typically stems from epidemiological research that does not attend to suicidal individuals' personal experiences of these issues or the way that the issues may be incorporated into treatment of suicidality. With a few notable exceptions from recent years (e.g., Crook, 2003; Everall, 2000), relatively little is known about how adolescents explain their own suicidal behaviour (Boergers, Spirito, & Donaldson, 1998); furthermore, only a few reports exist of how adolescents understand overcoming or dealing with their suicidality (e.g., Paulson & Everall, 2003), which is surprising given the emphasis in psychotherapy research on the client perspective (e.g., Greenberg, 1999). Instead, the bulk of the research in the area of adolescent suicidality has focused on identifying the statistically significant risk factors that may predispose adolescents to suicidality. This approach corresponds to and informs interventions mainly at the pre-primary and primary levels of health care (Cutcliffe, 2003), such as educational efforts and screening in the community, rather than treatment interventions.

Risk Factors in Adolescent Suicidality

Risk factors have been widely investigated, seemingly with two goals in mind: to facilitate the prediction of suicidality in adolescents and to inform its treatment, based on the assumption that amelioration of risk factors will prevent suicidality

(Hoover & Paulson, 1999). The identified risk factors can be classified in several ways (e.g., Stoelb & Chiriboga, 1998), but in general, they fall into three broad categories: psychological, behavioural, and social/environmental. Each of these categories is discussed below.

Psychological Risk Factors

An important psychological risk factor for suicidality is psychopathology; the association between suicidal behaviour and psychopathology has been demonstrated repeatedly (Stillion & McDowell, 1996) and adolescents with a history of suicidality have higher psychopathology severity scores (Mazza & Reynolds, 2001). The main psychopathological risk factor has been found to be depression (e.g., Pagliaro, 1995; Roberts, Roberts, & Chen, 1998), which is also perceived to be a significant factor by suicidal adolescents themselves (Kienhorst et al., 1995). There may be a gender differential for this risk factor: Joseph et al. (2003) remark that the comorbidity of suicide and depression is much higher for girls than boys. Other risk factors for suicidality in the context of psychopathology include conduct disorder (Brent & Apter, 2003), posttraumatic stress disorder (Mazza, 2000), personality disorders (Brent, Johnson, et al., 1994), and substance abuse disorders (Downey, 1990).

Factors related to cognitive processes also play a role in the development of adolescent suicidality. Everall et al. (2005) discuss several cognitive risk factors, such as suicidal adolescents' susceptibility to overgeneralization and selective abstraction. It has been found that adolescents' suicide attempts tend to be motivated by their cognitive constructions, rather than by interpersonal problems or by a cry for help (Boergers et al., 1998). Cognitive factors may also serve as intermediates between

other risk factors and adolescent suicidality. For example, Yang and Clum (1996) suggest that early environmental factors lead to increased risk for suicidal behaviour via their negative impact on cognitive factors such as self-esteem and locus of control. Interestingly, while depression is a strong risk factor for suicidality, certain cognitive variables influencing suicidality may also act independently of mood disorders; for instance, adolescents who attempted suicide were found to evaluate comparable events as more negative than their depressed but non-suicidal peers (Kienhorst, De Wilde, Diekstra, & Wolters, 1992).

Another significant risk factor for adolescent suicidality is gay, lesbian, or bisexual orientation (Bagley & Tremblay, 2000; Bobrow, 2002; McFarland, 1998; Russel & Joiner, 2001). Teenagers of these sexual orientations are overrepresented in the overall rates of completed and attempted suicide (Remafedi, 1999). This is likely due not only to the damaging effects of being the victim of overt homophobic abuse, but also to ostracism, lack of support from institutions and the adult gay community, and internalized homophobia (Gonsiorek, 1988). The very fact that pejorative slang terms that signify gay or lesbian sexual orientation represent for most adolescents the worst possible form of degradation speaks to the additional difficulties with social acceptance and self-identity development that non-heterosexual teenagers face.

Finally, other psychological factors such as inability to deal effectively with stressors and to obtain information required for problem solving have been found to be significant in adult suicidality (Horesh et al., 1996); however, such factors may not be relevant in adolescence. For example, Cole (1989) found that hopelessness, a risk factor often implicated in adult suicidality, is not significantly related to adolescent

suicidality; this may be due to the involvement of cognitive factors that are specific to adolescence, such as the belief that imminent external events (e.g., leaving school or moving away from home) will substantially improve the future. Beck and colleagues (Beck, Steer, Beck, & Newman, 1993; Rudd, Joiner, & Rajab, 2001, p. 18) concur that the relationship between hopelessness and suicidality in adolescence is uncertain. Recently, Thompson, Mazza, Herting, Randell, and Eggert (2005) found direct effects of hopelessness on suicidal behaviours in adolescence, thus the issue remains unclear. Hopelessness may be a mediator between depression and suicidality, and therefore may not be relevant in cases where depression is not part of the suicidal adolescent's clinical presentation.

Behavioural Risk Factors

In adolescence, a history of suicide attempts is one of the strongest risk factors for current suicidal thinking (Roberts et al., 1998) and for repeated suicide attempts, especially if the lethality of the initial attempt was high (Suokas & Loennqvist, 1991). On the other hand, in a study of adults who had attempted suicide, those who had repeatedly made attempts were less likely to have severe suicidal intent than those who had made only one attempt; the repeaters also acted impulsively more often (Oejenhagen, Regnell, & Traeskman-Bendz, 1991). Again, it is not clear how adult findings apply to adolescents. Though impulsivity has often been assumed to underlie adolescent suicidal behaviours, this is an unverified and prejudicial belief (Kienhorst, De Wilde, & Diekstra, 1994). In addition, despite the common myth to the contrary, adolescents' suicide attempts do not seem to be a function of risk-taking behaviour (Stanton, Spirito, Donaldson, and Boergers, 2003).

Furthermore, deliberate self-harming behaviours that may not be intended to result in death have been proposed to be another significant behavioural risk factor for adolescent suicide (e.g., Reith, Whyte, Carter, & McPherson, 2003). However, the nomenclature of self-injurious behaviour is often unclear due to confusion about the definition of such behaviour and its distinction from attempted suicide, both in the literature (O'Carroll et al., 1996) and in practice (Wagner, Wong, & Jobes, 2002). Therefore, research of risk factors related to self-injurious behaviours may not properly distinguish between actions with the intent of dying and those without, which may be partly caused by the difficulty in objectively distinguishing the two behaviours (Lowenstein, 2005). In general, however, suicidologists tend to view self-harming behaviour as distinct from suicide attempts, although the differences may be subtle (e.g., Muehlenkamp & Gutierrez, 2004).

As mentioned previously, substance abuse disorders are an important risk factor for suicide; however, substance abuse without necessarily involving addiction is also significant (Burge, Felts, Chenier, & Parrillo, 1995), leading to an increase in the incidence, repetitiveness, serious intent, and lethality of suicide attempts (Forman & Kalafat, 1998). The sheer availability of alcohol at home may contribute to suicide risk in adolescents (Sher & Zalsman, 2005). Forman and Kalafat observe that the prevalence of substance abuse in adolescents has increased significantly over time, in parallel with adolescent suicide rates, indicating a possible relationship between these two phenomena. Adolescent males may be particularly affected by such a relationship as they have greater likelihood than do adolescent females of being intoxicated at the time of a suicide attempt (Groves & Sher, 2005; Sher, Kandel, & Merrick, 2006).

Social/Environmental Risk Factors

This category is related to situational variables, life events, and social support factors. Under this umbrella, many studies have indicated variables related to family functioning to be important risk factors in adolescent suicidality. For example, Thompson et al. (2005) found lack of family support to have an influence on adolescents' suicidal behaviours; Brent, Perper, et al. (1994) discovered that a lifetime history of parent-child discord was associated with suicide in adolescence; Morano, Cisler, and Lemerond (1993) demonstrated that loss experiences and insufficient family support were the best predictors of adolescents' suicide attempts; and Kotila and Loennqvist (1987) showed that adolescents who attempted suicide repeatedly came from poorer social situations and less well-integrated families than those who had attempted only once. Similarly, Krarup, Nielsen, Rask, and Peterson (1990) discovered that adults who engaged in suicidal behaviour repeatedly were more likely to have had an unhappy childhood and a history of suicidal behaviour in the family or close environment.

Furthermore, although changes in family structure seem to have significant negative effects on adolescents' psychological well-being, including an increase in thoughts of suicide (Spruijt & de Goede, 1997), the impact of parental separation or divorce is overshadowed by that of parental psychopathology (Gould, Shaffer, Fisher, & Garfinkel, 1998). The risk factor of a deficient family environment – one that is unsupportive, stressful, conflictual, and lacking in cohesiveness – seems to exert its influence even prior to adolescence, as it was found to be the strongest predictor of suicidal behaviour in a study of preadolescent children (Asarnow, Carlson, & Guthrie,

1987). It is noteworthy that the various familial risk factors may exert their influence via adolescent psychopathology rather than suicidal behaviour per se (Miller, King, Shain, & Naylor, 1992), suggesting that the relationship between such risk factors and suicidality is indirect.

In terms of other social/environmental risk factors, it has been recognized that adolescents are vulnerable to the contagion effect of suicide, which involves imitation of suicidal acts (Moskos et al., 2004), seemingly triggered or disinhibited by news of another person's suicide. Sometimes referred to as "copycat" suicides, they may occur following high profile media reports of suicide (Rogde, Hougen, & Poulsen, 1996). Approximately 5% of adolescent suicides are thought to be influenced by the contagion effect (Hazell, 1993). Poijula, Wahlberg, and Dyregrov (2001) found that the contagion effect in high school students could be averted by instituting crisis intervention in schools following suicides. Interestingly, Watkins and Gutierrez (2003) found that adolescents exposed to the suicide of a friend or acquaintance did not differ from controls on measures of suicide risk or depressive symptomatology; although based on a small sample, the results suggest that the contagion effect may operate through subtle means.

Finally, other variables which may increase the risk for adolescent suicidality exist at the intersection of social factors and the biological developments of puberty. Kienhorst et al. (1995) note that within the last 150 years, the age of onset of puberty in both genders has decreased while societal changes have postponed the end of the adolescent period. This disjunction may place new stresses on adolescents for which

they are uniquely unprepared, as they must reconcile adult physical functioning with a child's social role.

Problems with the Use of Risk Factors

The risk factors that have been identified can help to predict which groups of teenagers may be more likely to experience suicidality. However, several problems exist with the use of risk factors in predicting adolescent suicidal ideation and behaviour. First, the isolation of distinct risk factors often leads to the erroneous conclusion that a single feature is predictive of suicidality (Kienhorst et al., 1995). However, the presence of a given risk factor does not necessarily lead to suicidality; the false-positive rate of using risk factors as predictors is high (McKeown et al., 1998). Second, because risk factors suggest vulnerability over long periods of time and may have limited implications for intervention, they are not equivalent to imminent warning signs (Rudd, 2003). Third, a generic model of suicide risk factors, applicable to all adolescents, may not exist. Hendin (1987) argues that instead of identifying the vulnerable subpopulations, it may be more useful to explore case studies of suicidal individuals in order to discover factors that distinguish them from matched controls who are not suicidal.

An additional benefit of Hendin's (1987) proposed research approach is that the identification of adolescents who are vulnerable to suicidality based on their risk factors but who do not experience it may facilitate the discovery of protective factors; such factors are responsible for these adolescents' resilience and coping in the face of adversity. It may be at least as important to understand the factors that protect against becoming suicidal as it is to understand the risk factors. Moreover, the vast majority

of individuals who experience suicidality in adolescence do not succumb to it – an assumption based on the fact that up to 10% of youth acknowledge having attempted suicide (e.g., Safer, 1997b) but suicide completions are obviously much less common. Thus, at any given time, there exists a relatively large population of adolescents who have made suicide attempts. Additionally, many other adolescents experience suicidal ideation, but do not progress to attempting or completing suicide. The study of risk factors in these groups may be less meaningful than the exploration of protective factors, both those which prevent the occurrence of suicidality in the first instance and those that defend against its continuation or exacerbation in affected individuals.

Protective Factors in Adolescent Suicidality

Research has focused to a lesser degree on protective factors than on risk factors in suicidality in adolescents. Some of the studies that have addressed protective factors reported that increasing family cohesion (McKeown et al., 1998; Rubenstein, Heeren, Housman, Rubin, & Stechler, 1989) and having close and supportive friends and families (Evans, Smith, Hill, Alberts, & Neufeld, 1996; Everall, Altrows, & Paulson, 2006) served as protective factors for suicidality in youth. Rubenstein et al. also found that a feeling of belonging in a larger social group, rather than simply having isolated friendships, was a protective factor.

Specific ethnic groups may exhibit distinct protective factors. For First Nations adolescents, higher levels of cultural preservation in the community have been found to be related to lower adolescent suicide rates (Chandler & Lalonde, 1998). A family history of receiving treatment for a psychiatric problem, more

frequent church attendance, and a high level of academic achievement have been found to be protective factors for Inuit youth (Kirmayer, Malus, & Boothroyd, 1996).

Despite the benefit of such research findings, factors identified as being helpful in preventing suicidality may not serve as protective factors for those adolescents who have already experienced suicidal ideation or behaviours. One reason is that such adolescents likely differ from non-suicidal peers, at least in terms of psychological needs or distress; another reason is that some protective factors, such as having a supportive social group or high academic achievement, cannot be utilized by the adolescent if they are not already in existence at the time of the suicidal crisis. Thus, the current literature seems more relevant to prevention efforts (Rogers, 2001) than to the treatment of youth who have already experienced suicidality. This poses a problem for mental health professionals who work with suicidal adolescent clients, because of the limited value of existing research in working with these individuals.

Treatment Approaches

Much of the current knowledge of treatment for suicidality is limited to crisis intervention, defined as the process of keeping the suicidal person alive in the short term (Leenaars, 1994) and to postvention, the treatment of the bereaved following suicide (Maples et al., 2005). According to Hoover and Paulson (1999), the literature on suicidality has tended to address assessment and short-term management rather than treatment, which is simply assumed to utilize traditional models of counselling. While comprehensive approaches to crisis intervention have been well explicated (e.g., Jobes et al., 2005), some researchers view the crisis intervention model as ineffective and possibly even detrimental (e.g., Rogers & Soyka, 2004). However,

reports of treatments that last beyond the crisis intervention phase are sparse and the efficacy of such treatments remains uncertain (Schaffer & Pfeffer, 2001). Moreover, much of the existing literature on the treatment of suicidality is not specific to the adolescent age group (Berman et al., 2006).

Counselling theories have typically addressed suicidality and its treatment in circumscribed terms and from narrow viewpoints. For instance, the psychoanalytic view focuses on exploring the client's unconscious processes; the existential approach stresses facilitation of the individual's search for meaning in their existence; and the cognitive-behavioural approach emphasizes the alteration of dysfunctional thinking patterns and the teaching of skills to correct faulty behavioural patterns (Corey, 1991). While these are valuable strategies, they are often studied in a disjointed rather than holistic fashion, which is due to the theoretical allegiances of most researchers. Thus, traditional models of psychological therapy are limited in the scope of their perspectives, so at best, they should be considered to be complementary approaches (Stillion & McDowell, 1996); at worst, if used in isolation, they may ignore critical elements involved in the multifaceted phenomenon of suicidality. Additionally, counselling theories rarely address the issue of clinical effectiveness, especially in relation to diverse client populations, as the theories are typically geared toward use with verbal and motivated adults. Berman et al. (2006) have concluded that there is a great need for growth in the field of clinical suicidology.

In view of the above issues, the investigation of effective treatments for suicidality in adolescence remains a neglected area of research. Although common sense suggests that the provision of psychological therapy to suicidal adolescents is

crucial, only a few researchers have addressed this issue in a rigourous fashion. One instance is March et al. (2004) who investigated the use of cognitive-behavioural therapy with depressed teenagers, some of whom were also suicidal, and found it to be somewhat effective; another instance is Rathus and Miller (2002) who found that dialectical behaviour therapy adapted for adolescents with borderline personality features was more effective than treatment than usual. However, similar to Brent's (2004) message that the key to intervention with suicidality lies in the development of treatments for depression, the above studies were based on narrow conceptualizations of suicidality as a symptom of a mental disorder (corresponding to a Kraepelinian model of mental health concerns; Berman et al., 2006). Thus, a comprehensive view of suicidality is lacking in some approaches to its treatment (e.g., Pelkonen & Marttunen, 2003; Schaffer and Pfeffer, 2001). One promising exception to this is an intervention developed recently by Beck and his colleagues (Henriques et al., 2003) for use with adolescents and young adults with suicidal behaviour, regardless of their psychiatric diagnosis and therefore independent of any mood or personality disorder.

Overall, knowledge of the effectiveness of treatments for adolescent suicidality outside of the context of narrow psychiatric conceptualizations (which may not be relevant in most counselling settings) seems to be limited mostly to isolated or anecdotal reports in the literature. For example, based on clinical experience, Berman (1987) recommends assessing risk factors in the home environment and including the family in all phases of evaluation and treatment; Orbach and Bar-Joseph (1993) found that treatment focused on confronting and exploring life experiences and difficulties related to suicidal behaviour, combined

with learning coping strategies, significantly reduced adolescents' suicidal feelings. Despite the scarcity of empirically derived and validated approaches to the treatment of adolescent suicidality, a movement seems to be underway in the psychotherapy field to remedy this dearth, which will allow the field to progress past the current stage of "infancy" (p. 180) in this research area (Berman et al., 2006).

Over the last decade or so, more emphasis has been placed on qualitative research in the area of suicidology. For instance, drawing on their phenomenological research, Hoover and Paulson (1999) advise exploring the patterns of disconnection, the vulnerabilities, and the resources in suicidal persons' lives, and focusing treatment on reconnection of these individuals with others and with themselves. These authors found validating relationships to be important in healing from suicidality. However, the study explored the experiences of individuals who had been suicidal in their adult years; it is not known if similar recommendations can be made for the treatment of suicidal adolescents.

Hoover and Paulson's (1999) assertion that relationships are critical in recovery from suicidality is echoed by Truscott, Evans, and Knish (1999), who recommend attending to the therapeutic alliance when working with suicidal individuals. This calls attention to the role of the therapeutic relationship between the suicidal adolescent and the mental health professional. The therapeutic alliance has been studied extensively in the adult counselling literature (see Bachelor & Horvath, 1999), generally validating the importance of the relationship. However, clinicians should not assume that adolescents are similar to adults (Everall & Paulson, 2001; Rotheram-Borus & Trautman, 1988) and, considering the developmental differences

between these two age groups, the therapeutic alliance with adolescents requires independent consideration.

Therapeutic Alliance with Adolescents

Until fairly recently, research had not addressed the elements required for satisfactory therapeutic outcome with adolescents (DiGiuseppe, Linscott, & Jilton, 1996). However, clinicians report that the therapeutic relationship is crucial to successful counselling with this population (Hanna, Hanna, & Keys, 1999). Rhodes and Links (1998) suggest that the early engagement of suicidal adolescents and their families in treatment is essential for preventing repeat suicide attempts and treatment dropouts. This engagement necessitates attending to the therapeutic alliance between the client and the professional.

The importance of the therapeutic alliance in counselling was first recognized some time ago; an influential study by Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) showed that the patient-therapist relationship is a critical predictor of outcome in psychotherapy. This finding, despite an ongoing "civil war" (p. 8) in the discipline of applied psychology which pits method allegiance against belief in common therapeutic factors (Lambert, Bergin, & Garfield, 2004), continues to hold true both in general therapeutic contexts and in work with suicidal people (Leenaars, 2004). In fact, it is generally recognized that in counselling with suicidal individuals, the therapeutic relationship is of primary importance (Leenaars, 2006). The American Psychiatric Association (2003) advises in its practice guidelines that the first step following assessment in the care of suicidal individuals should be the establishment and maintenance of a therapeutic alliance; similarly, Collins and Cutcliffe (2003)

state that the therapeutic relationship is a prerequisite for successful therapy with suicidal people, regardless of the usefulness of specific psychotherapeutic techniques in addressing suicidality. One reason for the significance of the therapeutic alliance may be that individuals who feel that they matter to others – a perception that the alliance may facilitate – are less likely to consider suicide, as Elliott, Colangelo, and Gelles (2005) discovered in a large-scale study of adolescents.

Much existing research on the therapeutic alliance stems from Bordin's (1979) transtheoretical model, which consists of three components: agreement between the client and the counsellor on the goals of therapy, agreement on the tasks of therapy, and the development of a therapeutic bond. Interestingly, DiGiuseppe et al. (1996) state that the majority of research on adolescent psychotherapy process has focused on the last of these three components – the therapeutic bond - and has assumed it to be sufficient to bring about change, essentially ignoring the other two components. However, agreement on tasks and agreement on goals may be particularly important to adolescent clients because of relevant developmental issues such as striving for independence and self-determination.

However, challenges exist in the formation of a strong therapeutic alliance with adolescents. Kazdin (1990) notes that youth rarely refer themselves for mental health treatment and may not consider themselves to be in need of treatment at all. The insight that change is desirable may therefore be lacking in these individuals (DiGiuseppe et al., 1996). Another problem lies with the ethical issue of limits of confidentiality in work with minor clients (Morris & Nicholson, 1993), which may complicate the establishment of a strong working alliance. Overall, DiGiuseppe et al.

assert that the establishment of such an alliance is more difficult with adolescents than with adults, and that it requires special consideration of factors such as age, presenting problem, and desire for change. This poses additional challenges to the mental health professional working with suicidal adolescents.

Paucity in the Current Literature

Several shortcomings of the current literature have already been mentioned, such as the lack of research on protective factors in adolescents with prior suicidal ideation or behaviours, and on effective counselling approaches to the treatment of suicidality, including the specific role of the therapeutic alliance. The following are additional areas in the literature on adolescent suicidality that have not yet been adequately addressed by research, but which seem critical to the topic at hand.

Focus on Attempted Suicide versus Completed Suicide

One problem with the current literature on adolescent suicidality is that most studies report and analyze rates of completed suicides; very little accurate information regarding suicide attempts is available. One reason for this may be that the reporting of data on attempted suicides stopped several decades ago (Sakinofsky & Leenaars, 1997). Secondly, community studies suggest that only a small minority of adolescent suicide attempters receive medical attention after their attempt (King, 1997); Everall (2000) notes that suicide attempts can thus often remain undiscovered, especially if medical or psychological care is not sought, and that suicide attempts may also be inadvertently or intentionally misclassified as accidents.

An additional problem is related to the one mentioned above. The results of many studies were obtained via psychological autopsy, a method designed to assess

the role of various factors in suicide following the person's death (Moskos, Olson, Halbern, Keller, & Gray, 2005). Psychological autopsy aims to identify common characteristics in suicidal individuals (Henry et al., 1994). However, psychological autopsy occurs only in cases of completed suicide, so it excludes the numerous adolescents who have considered or attempted suicide but did not die – and who thus would be able to provide subjective accounts of their experiences of suicidality.

Value of the Subjective Perspective

Researchers have identified the subjective perspective as important in fully understanding lived phenomena (e.g., Eddins & Jobes, 1994; Kienhorst et al., 1995). Researching the subjective perspective of clients receiving counselling is important because their experiences of the counselling process often differ from those of their counsellors (Bachelor, 1991; Elliott & James, 1989); in the study of mental health treatment, therapists' perceptions of their clients' experience may thus be inadequate (Kazdin, 1990). According to Everall and Paulson (2001), clients are able to convey essential information about the process of overcoming suicidal thoughts and feelings, which may help to inform treatment. However, little is known about suicidality or its treatment from the suicidal individual's perspective. It appears that Hendin's (1987) assertion that there is a lack of research on the treatment of suicidality based on case studies of individuals who survived suicide attempts still holds two decades later.

Notable exceptions to this paucity in research include Hoover and Paulson's (1999) examination of factors perceived by suicidal individuals as helpful in their recovery from suicidality, and Everall et al.'s (2006) investigation of the process of overcoming suicidality from the subjective perspective of previously suicidal

teenagers. Otherwise, however, most studies of adolescent suicidality have been of quantitative design and there remains a lack of qualitative research addressing clients' experiences from a subjective perspective. Therefore, the voices of those who have experienced adolescent suicidality and survived are largely absent in the literature. This study aims to rectify this absence, in line with recent research trends in the psychotherapy research literature that value the client's subjective perspective (e.g., Greenberg, 1999; Henkelman & Paulson, 2006; Paulson, Everall, & Stuart, 2001).

Rationale for Current Study

Although some facets of adolescent suicidality have been extensively researched, it continues to be a significant problem, and knowledge of effective treatment approaches is inadequate. Many of the studies to date have used paradigms focused on etiology and epidemiology, and researchers have often utilized the limited method of psychological autopsies to understand suicidality; there is a need for research that adds meaningful knowledge for practitioners working with suicidal clients. Noticeably missing from the literature is the perspective of those individuals most affected by adolescent suicidality: the adolescents themselves.

Evolution of Research Topic

My interest in this topic was piqued by my involvement as a research assistant in the Teen Suicide Research Project at the University of Alberta. This involvement included interviewing formerly suicidal adolescents and young adults; some of these individuals had experienced counselling in relation to their suicidality, and I found their stories of these experiences to be extremely interesting. However, I discovered

that such subjective accounts of counselling following suicidality were not reflected in the research literature, which stimulated my interest in pursuing the current study.

In preparation for my research, I carried out a pilot qualitative study of the counselling experience of one of the participants in the above project, an adolescent girl who had experienced suicidal ideation and subsequently received counselling. The results of the pilot study revealed intriguing facets of her counselling encounter, and led me to focus on this topic for my dissertation.

Research Question

Because of the lack of meaningful research on the psychological treatment of adolescent suicidality, the present investigation is exploratory in nature. Due to the ethical difficulties in soliciting currently suicidal teenagers for research participation, the study used retrospective accounts (as is often done in phenomenological research; Wertz, 2005) of participants who had previously experienced suicidality followed by counselling. Therefore, this study aims to answer the following research question: What are the counselling experiences of formerly suicidal adolescents? The next chapter describes the research design that was used to uncover such experiences.

CHAPTER 3: METHODOLOGY AND METHODS

This study is aimed at uncovering young people's experiences of counselling following suicidality in adolescence, a subject that has received limited attention in the literature. A qualitative approach is used to address this goal, and as such, uses inductive strategies (Merriam, 2002; Patton, 1990) that allow an in-depth exploration of the subject matter. Because "the construction of social reality from the perspectives of those living within a situation" (Stubblefield & Murray, 2002, p. 149) is considered vital in understanding human phenomena, I chose to use interpretive phenomenology (also referred to as hermeneutic phenomenology) to answer the research question. This approach is described below.

Phenomenological Perspectives

Because phenomenology has various schools of thought and practice, I first provide a brief description of phenomenological approaches to clarify my choice of research methods. Edmund Husserl, recognized for founding the phenomenological method in the early part of the 20th century, believed that experience is constituted by consciousness and can be studied on the basis of how it appears to consciousness (Hein & Austin, 2001). He proposed the process of self-reflection as the method to uncover the essence – the necessary universal structure – of a given object or event (Klein & Westcott, 1994), thus, the traditional phenomenological approach based on Husserl's philosophy focuses on the study of human consciousness and its essential structures. When applied to research in the field of psychology, phenomenological approaches aim to analyze concrete accounts of experience obtained from research

participants, rather than from the researcher's own self-reflection as is typically done in the field of philosophy (Hein & Austin, 2001).

Husserl's phenomenology subsequently became influenced by existential philosophical thought, leading to the emergence of existential phenomenology – best represented in the works of Martin Heidegger, who shifted the focus of inquiry from consciousness to more general aspects of human existence (Hein & Austin, 2001). Several differences exist between Husserl's and Heidegger's approaches. Instead of focusing on "Being" as did Husserl, Heidegger concentrated on "Being-in-the-world" (Churchill, 2000). Therefore, Heidegger's phenomenology is distinctly interpretive as it focuses on an individual's contextual, situated experience, rather than experience in a more abstract form, based on the view that "knowledge originates from people who are already in the world and seeking to understand other people who are already in the world" (Lowes & Prowse, 2001, p. 474).

Due to the diversity in its philosophical roots, phenomenological research can be categorized in various ways and encompasses several distinct research methods (Klein & Westcott, 1994). For instance, Stubblefield and Murray (2002) classify phenomenological studies based on Husserl's philosophy as descriptive, and those based on Heidegger's philosophy as interpretive. In turn, interpretive approaches to phenomenological research have also been labeled as hermeneutic (Hein & Austin, 2001). Hermeneutic inquiry is the tradition, philosophy, and practice of interpretation (Moules, 2001) with historical origins in the interpretation of biblical and other ancient texts (Hein & Austin, 2001).

Hermeneutic phenomenology has unique characteristics and goals. Whereas Husserl's phenomenology assumes that there is a shared essence of experience among humans, requiring that the essence of a phenomenon identified in research must apply to all people (Klein & Westcott, 1994; Patton, 1990), no such claim of universality exists in Heidegger's hermeneutic phenomenology (Churchill, 2000). The aim of the latter approach is to uncover lived phenomena through a process of contextualization and amplification, and not just structural essentialization (Hein & Austin, 2001); as Moules (2001) notes, the hermeneutic approach aims to bring a given phenomenon to presence, rather than to extract its essence. In other words, in contrast to Husserl's requirement that research bring forth the universal essence of a human experience, Heidegger's hermeneutic phenomenology focuses on understanding the experience in its entirety and idiosyncrasy. Moreover, Heidegger's approach allows for multiple interpretations of research data, unlike Husserl's approach, which permits only one understanding of the results (Hein & Austin, 2001).

Hermeneutic Phenomenology

In approaching the study of counselling experiences related to suicidality in adolescence, I wanted to be open to the similarities and differences that may exist among the participants' accounts, and, as I expected their experiences to be quite multifaceted, the search for a universal essence in these experiences was not the primary objective. Because hermeneutic phenomenology presented itself as a good methodological fit to the topic at hand and the constructivist tenets of this approach (Ponterotto, 2005) generally parallel my own philosophical views, I decided that it would be a suitable approach to address the research question.

This study is methodologically based on the writings of Patricia Benner (e.g., 1985; 1994). In her approach to hermeneutic phenomenology, which she derived from the aforementioned philosophy of Heidegger, interpretive strategies permit the presentation of context with the goal of achieving situated understanding. Indirect discourse is used to uncover naturally occurring concerns and meanings in human experience. The researcher aims to present the text and its interpretations as fully as possible, along with the identification of any puzzling or incongruent findings.

Benner's approach to hermeneutic phenomenology is somewhat distinct from that of Max van Manen, a noted scholar in the field; van Manen (1997) focuses more overtly on studying lived phenomena as they are experienced in consciousness and on grasping the essence of such phenomena. According to Dowling (2007), van Manen's approach incorporates aspects of Husserl's phenomenology, which is located within positivism (Racher & Robinson, 2003) due to Husserl's view of essence as existing independently of conscious experience (Mackey, 2005), as contrasted with Benner's more overtly interpretivist stance based on Heidegger's phenomenology. While the present study does seek to identify participants' common experiences via thematic analysis, and as such, does not reject the notion of essentiality, there is no explicit objective to find the essence of their experiences. Instead, the emphasis is on the contextualization and amplification of the findings (Hein & Austin, 2001); in other words, the aim is to present participants' shared experiences and shared meanings in as rich a form as possible while situating these findings within the lifeworlds of the participants. This goal is facilitated in this study through the use of Benner's (1985) presentation strategies of paradigm cases and exemplars (to be discussed shortly).

Bracketing

Because the focus of phenomenological research in psychology is typically on exploring other people's experiences, it has been argued that researchers must engage in a suspension of their beliefs and biases, a process referred to as bracketing (Klein & Westcott, 1994). This process involves rigourous self-reflection and articulation of one's presuppositions; however, a truly presuppositionless stance is unattainable, because interpretation based on a priori understanding of the subject matter is inherent in the study of human existence (Hein & Austin, 2001).

Nevertheless, Hein and Austin (2001) indicate that a process akin to bracketing is still important in order for researchers to acknowledge their implicit assumptions and perspectives, to increase their own awareness of influences on the research process, and to make these influences explicit to the reader, so that the reader can be aware of the perspective from which the research was carried out and thus take this perspective into account when evaluating the findings. Full explication of such presuppositions facilitates the demonstration of rigour in research (Lowes & Prowse, 2001). Therefore, I describe my own views regarding adolescent suicidality and the counselling process below and throughout the rest of the document, where relevant.

My presuppositions.

I believe that suicidality is generally an undesirable phenomenon because it leads to suffering and a premature end to human life. Furthermore, my view is that overcoming suicidality is a positive endeavour that can be facilitated by counselling. Based on this belief, I see the beneficence of counselling in this context to be related to its role in aiding the resolution of suicidality. My assumption in this study is that

the participants volunteering to tell their stories will share these views, and will be agreeable to describing their experiences for the purpose of furthering research into the treatment of suicidality.

My own personal experience with adolescent suicidality has been the loss of two schoolmates to suicide during junior and senior high school. These experiences left me puzzled due to their inexplicability at that time. Until then, I had believed that only teenagers who were "bad" (i.e., abusing drugs, making irresponsible life choices, or behaving immorally) could be suicidal. Incidentally, the topic of suicidality was taboo in the Catholic schools I attended, reinforcing its stigma. The secretiveness surrounding suicide made me uneasy, and I could not reconcile my preconceptions about suicidal adolescents with the knowledge that I had of the schoolmates who had committed suicide. I believe these early experiences stimulated my initial interest in the subject of suicidality.

During my undergraduate studies, I volunteered for a peer counselling organization, partially in order to explore counselling as a potential career. Training for the volunteer counsellors included assessment of suicide risk and basic strategies of intervention. This training and the subsequent experience of counselling suicidal individuals taught me a great deal about suicidality and the process of counselling. Perhaps most importantly, I learned that an empathic, non-judgmental response on the part of the helper can make an enormous difference for the suicidal individual. As a result, I believe strongly in the power of the therapeutic bond between client and counsellor in allaying clients' psychological distress, including suicidality.

My experience as a graduate student in counselling psychology, while rich in the theories of counselling, incorporated limited application of these theories to the treatment of suicidal individuals. When suicidality was addressed, this was done in the context of depressive symptomatology, and thus treatment was assumed to take place within this framework as well. This approach may not really acknowledge the existential elements of suicidality or the potential value of alternate approaches to its treatment. I was left wanting to know more about suicidality and treatment options.

Finally, as a psychologist, I have worked extensively with adolescents and young adults in two treatment settings where I have encountered several suicidal clients. These occurrences have taught me that the experience of suicidality, like its treatment, is multi-faceted and often complex, and they have reinforced my belief in the value of the therapeutic relationship. In particular, one client had been suicidal for several years and had set a suicide date for herself (her 21st birthday), which was fast approaching. I took an empathic yet change-focused approach to working with her, which seemed to help. My research question in this study was partly born out of a desire to better understand this kind of transformative experience of counselling.

In order to maintain awareness of my biases and predispositions throughout the course of the study, I engaged in a rigourous process of self-reflection. This task involved an exploration of my thoughts and feelings about the topic and the research itself. It took the form of reflecting on and writing down my ideas, discussing the relevant or troubling ones with my research supervisor and colleagues from a student research group, and incorporating resultant insights into this document.

Research Design

Klein and Westcott (1994) remark that there is a wide diversity of methods in research based in phenomenology; furthermore, the literature does not dictate the use of one particular method (Hein & Austin, 2001). In general, however, analysis in hermeneutic inquiry is synonymous with interpretation and involves meticulous reading and rereading of the research text, which enables general impressions to emerge (Moules, 2001). The research text in the present study took the form of narrative material containing the experiences of interest, as explicated below and presented as participant stories in the following chapter (i.e., Chapter Four).

Use of Narrative Material

Hermeneutic research is a systematic approach to interpreting a text – text that may be obtained via transcription of participant interviews (Benner, 1985). However, I found it difficult to glean a sense of meaning from reading interview transcripts, as the experiences therein were often disjointed, tangential, and/or not in temporal order. I decided to first write narrative accounts of the participants' experiences on the basis of the interview transcripts, and then subject these narratives to hermeneutic analysis; one goal of analyzing narrative materials is interpretation of meaning (Smith, 2000).

Narratives are stories that people tell of their lives, and they are the most appropriate linguistic form for expressing human experience (Polkinghorne, 1994). People's stories allow better understanding of their experiences as lived, interpreted, and expressed (Oliver, 1998). The role of storytelling is fundamental in interpretive phenomenology, as it facilitates contact with the participants' experiences (Benner, 1994).

People attempt to make sense of their experiences by putting significant life events into a narrative format (Ochberg, 1996). Furthermore, the core element of narratives is plot (Oliver, 1998), the structure via which individuals understand and explain their life experiences (Polkinghorne, 1994). Thus, the temporality inherent in the plot is an important feature of narratives. Polkinghorne (1995) instructs that the first step in configuring research data into a narrative format is the chronological arrangement of the data elements; the next step is the identification of the elements which are contributors to the outcome; and the final step is the writing of the story by drawing together those elements into a systemic whole.

Using these guidelines, I synthesized the participants' descriptions of their counselling experiences related to adolescent suicidality into chronological narratives, which are presented in the next chapter. This process of constructing the narratives helps the researcher to understand participants' lives, environments, and subjective realities (Oliver, 1998). I also trust that the narratives will allow the reader to gain a holistic understanding of the participants' experiences, and render my analysis more transparent and trustworthy.

Interpretation was kept to a minimum in the narratives; I attempted to stay as true as possible to the words and phrases used by the participants in their interviews. Nonetheless, due to my task of paraphrasing and synthesizing the accounts, some degree of interpretation on my part was unavoidable even at this initial stage of writing, and this needs to be acknowledged in line with Polkinghorne's (1995) assertion that the researcher's role in shaping the narrative must be recognized. Interpretation plays a key role in the analysis of narrative material; all levels of

narrative representation, including the telling, the documentation, and the analysis, are interpretive (Riessman, 1993). Nevertheless, my intent was to lose nothing of significance to the topic at hand in the process of writing the participants' narratives; all relevant participant quotes were maintained verbatim, upon which the thematic analysis was based. The original quotes from the transcripts were utilized to support my findings and to show robustness of the narratives. Robustness was also ensured through my asking the participants themselves to verify the narratives as being reflective of their experiences.

Interpretation of Meaning

The meaning that emerges from any qualitative research can be viewed as shared, in that it incorporates both the participants' and the researcher's meanings of phenomena (Hein & Austin, 2001). Inviting feedback and discussion at the stage of analysis from other researchers or people experiencing the phenomenon of interest can enrich the emerging interpretations (Crist & Tanner, 2003). Readers further interpret the researcher's interpretations (Churchill, 2000); thus, the interpretive process is iterative and involves more than just the researcher.

The researcher enters imaginatively into the consciousness of the participants; furthermore, in hermeneutic analysis, there is an emphasis on extensive elaboration on the participants' actual words and the use of creativity in interpreting text (Klein & Westcott, 1994). Cutcliffe and McKenna (2002, 2004) note that the goal in qualitative inquiry is to "go beyond the words, see past the obvious, [and] access the underlying and the hidden" (p. 130) via, at least in part, harnessing of the researcher's creativity and interpretive skills. Hein and Austin (2001) also observe that hermeneutic analysis

goes beyond the literal or explicit meaning of the words used by the participants in order to reveal implicit or latent meanings, and that this is achieved via the use of intuitive capacities.

My training in counselling psychology and experience as a psychologist assisted my process of entering empathically into the participants' lifeworlds and identifying salient patterns in their narrative accounts. Benner (1994) confirms that conducting interpretive phenomenology is analogous to clinical reasoning because of the requirement in both endeavours of engaged analysis within a situation focused on experience. I found that writing and analyzing each participant's story did indeed resemble documenting a therapy session, albeit in a more detailed fashion and without the element of planning therapeutic interventions.

The hermeneutic circle.

Benner (1985) explains that hermeneutic analysis involves a recursive process of studying the whole text and parts of the text in order to reveal new understanding. This process, referred to as the hermeneutic circle, is defined as "the practice of cycling back and forth between an interpretation of the text as a whole and the use of this interpretation to illuminate the meaning of individual parts of the text" (Klein & Westcott, 1994, p. 140). Follesdal (2001) further explains the hermeneutic circle as a process in which the researcher goes back and forth between the parts and the whole until a fit is achieved in the interpretation. Over the course of this study, I found that I often had new insights regarding previously analyzed material, at which point I would again enter the circle to find a new fit between the narratives and my interpretations.

The hermeneutic circle necessitates immersion in the text via reading, rereading, reflection, and writing (Moules, 2001), thus it requires sustained and focused attention. However, my attention to the study was interrupted several times over its course due to changes in my personal life. I found that upon re-immersing myself in the research after an interruption, I was able to use some of the interim experiences (such as counselling encounters with adolescents) to assist me with the continuing analysis. However, it was certainly challenging to follow the advice of Crist and Tanner (2003) to not lose sight of each participant's context within the emerging interpretations, and I needed to reread their stories countless times throughout the course of the analysis to stay close to their experiences.

Follesdal (2001) remarks that researchers must approach the text with openness and awareness of their preconceived notions regarding the subject matter, and that a main task of hermeneutics is to adapt these preconceived notions to the text; my reflections in this regard are discussed in the last chapter. Churchill (2000) observes that the hermeneutic circle encompasses not only the researcher's process, but also the reader's process of reflecting on the findings. The hermeneutic circle truly has no endpoint in interpretive analysis.

Process of Research in the Current Study

In this section, I describe the criteria for participant inclusion, the interview guidelines, the ethical considerations, and the analytic procedure used in this study.

Criteria for Participant Inclusion

The goal in participant selection for this study was to find individuals who had been suicidal – i.e., experienced suicidal ideation or suicide attempts – as adolescents

(defined in this study as ages 13 through 19), had received counselling in relation to the suicidality, and wished to share their stories for the purpose of research. Such a sample is purposeful, because it involves individuals sought out for certain qualities or criteria and who can give information-rich accounts of their experiences (Patton, 1990), which is desirable as these individuals can best address the research question. In addition, participants' counselling should have occurred no more than five years prior in order to aid recall, and, in order to minimize potential risk of psychological distress given the sensitive nature of the research topic, participants had to be free of suicidality for at least a year prior to the interview. To summarize, participants must have:

- Experienced suicidal ideation and/or behaviour between the ages of 13 and 19.
- Received at least one session of individual counselling with a mental health professional in relation to this suicidality (with no upper limit on sessions), preferably within the past five years.
- Experienced no suicidality for a minimum of one year prior to the interview.
- Demonstrated willingness and ability to provide a verbal account of the experiences of interest.

Based on recommendations in the literature regarding sample size (e.g., Sandelowski, 1995), I anticipated that approximately 5 to 10 participants would be included in the study; in the end, 5 individuals took part. Each participant reported between two and four discrete experiences of counselling relating to suicidality in his or her youth; so the number of distinct counselling experiences analyzed in this study was 14, each of which was with a different counsellor. The decision to stop inclusion

of new participants was made at this point, because extremely information-rich accounts of counselling experiences had been provided by the participants, and I observed that the same general themes were emerging repeatedly in the accounts; these common themes also fit with my findings from the pilot study carried out previously. The richness and the redundancy in the findings were sufficient to proceed with interpretive analysis.

While I discovered that redundant themes were evident in the participants' rich accounts, it is difficult to determine if saturation in the findings was achieved. Saturation – the point in the data collection process at which no new information is obtained (Gubrium, 1995; Guest, Bunce, & Johnson, 2006) – may be less vital in hermeneutic phenomenology than in some other qualitative approaches, such as grounded theory, in which the objective is the development of a theoretical model (Kuzel, 1999). In fact, since the inquiry in hermeneutic phenomenology is circular and thus never final, there may be no saturation point in such research (Bergum, 1991).

Solicitation of participants occurred in two forms throughout the community: advertisements describing the research study and the participant criteria were placed in a citywide community newspaper and on public bulletin boards. Upon telephone contact with a potential participant, I explained the study in detail and carried out a brief verbal screening, in which fulfillment of the participant criteria was assessed. I also explained the study to the participant's parent or legal guardian, where necessary due to underage status. If the potential participant, and the parent or guardian, were interested in taking part in the study and fit the criteria, an appointment was made to

meet at a mutually convenient time, either at a centrally located counselling clinic or in the participant's home. Inclusion of new participants in the study, assuming they fit the criteria, was on a first-come, first-served basis. Participants were each paid $20 plus parking or transit expenses as a token of appreciation for their involvement in the research. Approximately 5 additional respondents to the advertisements either did not fit the participant criteria or made contact after redundancy in the findings was found.

Interview Guidelines

During the initial meeting with participants, the study was again described in detail verbally and in writing (see Appendix A). Informed consent was obtained from them or, when necessary due to their underage status, from their parents or guardians; in the latter case, informed assent was also obtained from participants. Corresponding forms (see Appendix B) were signed and dated. Next, a minimally structured research interview was conducted. The meetings lasted between one and two and a half hours, with the average being approximately two hours. Interviews were audio recorded and later transcribed verbatim into text.

The interviews were always started with a broad question asking about the participant's experiences of counselling following suicidality in adolescence – for example, "What was the counselling like for you?," "What was your experience of being in counselling?" and "What was important about that counselling experience?". To facilitate the interviews, I utilized an interview guide (see Appendix C) consisting of several questions that could be asked of participants. The purpose of the questions was to prompt rich accounts of participants' counselling experiences, in case such descriptions were not already being provided. In order to assist the participants'

reflection on their counselling experiences and in line with psychotherapy research methods that utilize the client perspective (e.g., Greenberg, 1999), some interview questions also elicited participants' advice with regard to counselling for suicidal adolescents and for therapists working with such adolescents. Notwithstanding the prepared questions, I always allowed the participants rather than the interview guide to steer the direction of the interview. Thus, some questions were elaborated and others were paraphrased, depending on need; for instance, I frequently utilized less formal language, such as "What was 'x' like?" versus "What was your experience of 'x'?" if the latter wording was felt to hinder rapport or comprehension. In addition, participants varied widely in terms of verbal output and response comprehensiveness during the interviews, so my level of active questioning varied accordingly; certainly not every interview question needed to be asked of each participant, nor were the questions always asked in the same order.

One criterion of trustworthiness in qualitative research is correspondence, or recognizability of the researcher's work by participants as an adequate representation of their experiences (Riessman, 1993). Accordingly, following my construction of narratives, I sent each of the participants a copy of his or her individual story and attempted to obtain their input regarding these narratives in a follow-up conversation. In addition to the opportunity for participants to clarify ambiguities in their stories, Riessman notes that this process can provide researchers with further theoretical insight. In my study, four of the five participants did not suggest any changes to their respective narratives; one participant could not be reached despite multiple attempts to do so.

Ethical Considerations

This study has been approved by the Faculties of Education and Extension Research Ethics Board at the University of Alberta. Several ethical issues had to be considered in carrying out the study, especially in light of the sensitive nature of its topic, including anonymity, confidentiality, benefits to participants, potential risks to participants, and free and informed consent and assent. Each of these ethical issues is addressed below.

Anonymity and confidentiality.

Due to the personal and sensitive nature of the research subject matter, it was extremely important to protect the participants' anonymity in the public domain both during the process of interviews and in the written document, which will be available publicly. All stages of my contact with the participants were as discrete as possible in order to not divulge their identities to others (e.g., counselling clinic staff). I disguised the participants' identities in the written document via the use of pseudonyms chosen by the participants and the omission or alteration of identifying personal information, such as the names of schools, hospitals, and counsellors.

Participants' confidentiality was protected by conducting the interviews in a private room in a counselling clinic or in the participant's home, and by keeping all records of the study in a secure locked location, where they will remain for 15 years following transcription, at which time they will be destroyed. I considered myself bound to confidentiality at all times by the Standards for the Protection of Human Research Participants (University of Alberta, 2002) and the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2000).

Risks and benefits to participants.

It was foreseen that participants would face potential risks in the form of psychological distress upon describing their experiences of suicidality or counselling, as these were likely to be emotionally charged topics. In order to mitigate such risks, participants must have reported having made no suicide attempts and having been free from serious suicidal ideation for a minimum of one year prior to the interview. In the initial telephone contact and at the start of the interviews, I screened each of the participants regarding the above criteria and utilized my skills as a clinician to assess their situations, including factors (e.g., emotional lability or currently unstable living situation) that may have increased their vulnerability in the context of the study. The participants and their parents or legal guardians, where applicable, were informed of the potential risks prior to giving their consent or assent to participate. In addition, provisions were made for counselling services to be available to them, to serve as a safety net in case they suffered emotional distress following the research interview; the participants and their parents or guardians, where applicable, were given a list of free or inexpensive counselling resources in their geographical area. It was made clear that I, despite my training in counselling, would not be able to serve in a counsellor's role in order to prevent dual relationships. None of the participants appeared to be or reported being distressed at any point in the research. However, if they had, and if further involvement in the study had been judged to pose additional risk to them, my fiduciary role as an applied psychology researcher would have necessitated ending the research relationship, a strategy supported by Haverkamp (2005).

Other than the monetary remuneration, no direct benefits to the participants were foreseen to result from engaging in the study. Nevertheless, because participants knew the purpose of the study, they may have appreciated having a role in furthering research; presumably, this is the main reason for their interest in the study, as there was no mention of remuneration in the advertisements. Engaging in the research may also have been a way for participants to tell their stories, as was the case for one of the participants (Matt) who specifically mentioned wanting other people to know about his experiences.

Free and informed consent and assent.

I made an effort to ensure that the consent or assent provided by participants and their parents or guardians was free and informed. Prior to their engagement in the research, I provided a full explanation of the purpose of the study and the procedure involved in the research, and answered any questions. In addition, participants and where necessary, their parents or guardians, were made aware of the ethical issues discussed above and how I handled them in the study, and signed appropriate forms (see Appendices A and B). They were informed that they could withhold or withdraw consent or assent at any point during the study until the final document was written, and that doing so would not negate their remuneration in any way. Notwithstanding the above, I viewed obtaining consent and assent as continual processes rather than static events, as has been advocated in the literature (e.g., Munhall, 1988; Usher & Arthur, 1998), and in line with the ethics-as-process approach in qualitative inquiry which views research as a process with dynamic, negotiated ethical dimensions and facilitates responsiveness to emergent ethical issues (Cutcliffe & Ramcharan, 2002;

Ramcharan & Cutcliffe, 2001). Accordingly, I monitored participants' consent and assent throughout my contact with them by watching for possible changes in these regards (Haverkamp, 2005; Smythe & Murray, 2000), which did not materialize.

Method of Analysis

As in much phenomenological research within the field of psychology, no single analytic method is championed in the hermeneutic approach. Based on the suggestions of Hein and Austin (2001), I used the extant literature on hermeneutic phenomenology as a general guideline for my research and then used the suggested methods to meet the needs of this study. Benner (1985; 1994) and other researchers (e.g., Crist & Tanner, 2003; Stuhlmiller, 2001) have identified general strategies that can assist in the interpretation of meaning of textual and narrative data. Based on this literature, the analytic procedure consists of four strategies and is described below.

First, the researcher must read the narratives in their entirety several times in order to gain a holistic understanding of the participants' experiences. This involves immersing oneself deeply in the text and it forms part of the rigour of the hermeneutic method (Paterson & Higgs, 2005). I found that returning to reread the participants' narratives at various points throughout this study allowed a fresh perspective and new insights to develop. I also utilized an "interpretive team" as suggested by Crist and Tanner (2003), by asking my research supervisor and student colleagues to read the narratives and share their reactions with me. This helped me to attend to the obscure nuances in the narratives and to glean a richer understanding of the experiences.

The second strategy involves conducting a thematic analysis of the textual data by examining the narratives in detail in order to discover their common themes.

This process is inductive in that a given unit of data, such as a meaningful phrase, is compared to another unit of data, and so on, in order to detect patterns across the data (Merriam, 2002). Each of the narratives is explored to identify themes with a focus on similarities and differences rather than frequency, as demonstrated by Hinck (2004). The goal is to uncover the meanings underlying the commonalities and distinctions (Benner, 1994). The within-case analysis then shifts to an across-case analysis and the common themes that emerge consistently are named. In identifying common themes, I generally used the requirement that the topic or idea had to be present in more than one but not necessarily all narratives, based on a commonly–used criterion in phenomenological research in psychology (Klein & Westcott, 1994).

In hermeneutic phenomenology, many possible perspectives on any given phenomenon are assumed to exist; the analogy of turning a prism, which refracts light differently from different angles, has been used to illustrate the concept of uncovering such multiple perspectives (Hein & Austin, 2001). Therefore, the use of additional interpretive strategies can help to increase understanding. The third strategy in this research involves the identification and interpretation of paradigm cases which depict a strong pattern of meanings in the textual data (Benner, 1985). Paradigm cases may be seen as particularly compelling participant stories (Crist & Tanner, 2003) or vivid descriptions of participants' ways of being in the world (Hinck, 2004), illustrating patterns and variations in their experiences that the thematic analysis may not have illuminated; they allow the researcher to see facets that the participants did not necessarily address directly. In effect, paradigm cases are those narratives that provide paradigmatic shifts in understanding (Benner, Tanner, & Chesla, 1996).

Hinck (2004) notes that paradigm cases allow similarities and differences between the participants to become more recognizable. To this end, Benner (1994) suggests the exploration of contrasting cases: "once one paradigm case is developed, a second case is examined in its own terms and in light of the first paradigm case" (p. 114). Also, when putting paradigm cases into written form, Hein and Austin (2001) suggest examining the participant's narrative for evocative images, exploring these images via disciplined reflection, and arranging them into text in a manner that may go beyond the immediate experience of the participant. Hein and Austin remark that creative means of expression at this stage can reveal human experience in a way that has typically eluded psychology.

Finally, the fourth strategy involves locating and reporting exemplars of participants' experiences that seem particularly meaningful in illustrating the themes and the paradigm cases. Exemplars are salient excerpts from participants' narratives that exemplify common themes or meanings in their stories (Crist & Tanner, 2003). These short segments are extracted from the text to help illustrate similarities and differences between participants; therefore, multiple exemplars are useful because they present different nuances of an experience or pattern (Benner, 1994; Hinck, 2004). According to Benner, the goal of collecting a range of exemplars is to allow the reader to recognize the distinctions made by the researcher in the interpretations.

It must be noted that the above four stages are not necessarily chronological steps, as different authors present them in various sequences. For instance, Benner (1994) notes that paradigm cases can promote understanding early in the research process, in addition to being used as a presentation strategy later in the process. The

stages are presented here sequentially only in order to facilitate a systematic approach to interpretation within the nonlinear methodology of hermeneutics, as recommended by Crist and Tanner (2003). My experience was that owing to hermeneutic circularity, the interpretive process was recursive and the outcomes of the individual steps tended to enrich each other and inform new understandings, which in turn often necessitated a return to one or more of the four stages in the analytic procedure, from which yet new understandings arose.

Interpretive Procedure

Based on the above guidelines, I carried out the following steps to facilitate hermeneutic analysis of participants' experiences. Transcripts of the participants' interviews were read several times to engender familiarity with the content and its nuances. Secondly, because the life events described by participants in the interviews were usually chronologically disjointed and at times, tangential to the study topic, the relevant quotes were arranged on paper into chronological order for the sake of clarity in reading and interpretation. Narratives of each participant's described experiences were then developed, utilizing the salient quotes complemented by paraphrased text allowing greater narrative flow. Participants were each given a copy of their story and the opportunity to suggest changes; based on their feedback, no editing was needed.

Thematic analysis.

In each of the narratives, information related specifically to counselling experiences in the context of suicidality was highlighted for further attention. In order to conduct the thematic analysis, a procedure informed by Merriam's (2002) approach to basic interpretive qualitative research was utilized. The individual stories were first

analyzed independently to identify important ideas within each text, and inductive reasoning was used to identify the initial themes in each story. The resulting first order theme structure was modified several times by rereading the stories and searching for supporting as well as contradicting information with respect to the themes.

A between-person analysis of the initial themes in the stories was carried out, looking for commonalities among the individual narratives to emerge, resulting in a higher order theme structure. Each of the narratives was reviewed to ensure that no important ideas had been overlooked. Additionally, if a participant's experience did not fit with an identified theme, either that theme was modified to accommodate the experience or the incongruence is discussed in the relevant section of the findings. Minor modifications to the higher order theme structure were made as necessary in order to be consistent with the nuances present in the individual stories; for example, the names assigned to the theme headings were adjusted in several instances to better reflect those nuances. At this point in the analysis, approximately 11 distinct themes had been identified. The themes were then grouped based on inductive classification into yet a higher order theme structure; this yielded five overarching themes that encompassed several subthemes roughly corresponding to the previously identified 11 themes, and that were then named. For reference purposes, Appendices D and E provide a visual representation of the above processes and outcomes.

The analysis of themes was written up with thorough explanation of each theme and its subthemes, and inclusion of exemplars in the form of direct participant quotes. The specific exemplars were chosen on the basis of salience in illustrating the

given themes. The chosen participant quotes were then edited for redundancy with the participant stories in order to facilitate readability. Whenever redundancy was found, the given quote was maintained verbatim as an exemplar in the thematic analysis section in this document and was paraphrased into textual description of the experience in the participant's narrative.

Paradigm cases.

A second method of interpretive analysis was used in addition to the thematic analysis. Paradigm cases are a recognitional and presentation strategy (Benner, 1985) that allows the contextualization and amplification of findings – the cornerstone of hermeneutic phenomenology (Hein & Austin, 2001) – because particular cases are highlighted within a specific context. The contribution of paradigm cases is that they facilitate new ways of understanding of the phenomenon under study (Benner, 1996), corresponding to the view that many possible perspectives on a phenomenon exist (Hein & Austin, 2001).

At several points throughout the analytic process, I found that a few stories or experiences stood apart from the others in terms of their vividness or contribution to shifts in my understanding of the phenomenon under study. Corresponding to the strategies described previously, these instances were identified as paradigm cases. Specifically, two paradigm cases were chosen on the basis of having a powerful impact on me upon my hearing and reading the descriptions of those participant experiences. In line with Benner's (1994) recommendation of using paradigm cases that are contrasting, the two cases I chose are divergent in terms of the content of the participants' accounts; they portray positive and negative experiences in counselling.

In analyzing the paradigm cases, a process of incorporating intuition and "reading between the lines" was utilized, by exploring the cases for unarticulated meaning and salient experiences which had not been illuminated by the thematic analysis. In effect, I searched for the overall sense or message emanating from the participant's narrative. The two paradigm cases were written up using an approach that is more creative and metaphorical than that employed in the thematic analysis. Each paradigm case is illustrated with exemplars in the form of participant quotes.

Throughout the thematic analysis and the identification of paradigm cases, a recursive process was employed in line with the philosophy of the hermeneutic circle. Additionally, at several stages of this process, feedback from my research supervisor, members of my supervisory committee, and colleagues from a student research group in regard to the evolving findings supplemented the hermeneutic analysis process.

Trustworthiness of the Findings

Specific criteria are used to evaluate the outcomes of qualitative analyses in terms of trustworthiness (Alvermann, O'Brien, & Dillon, 1996). Ponterotto (2005) notes that rigour must be judged on the basis of a qualitative study's thick description, referring to the richness and detailedness of the presentation of phenomena and their context. I have provided such thick description in this document via the inclusion of participant narratives in the next chapter, devoted exclusively to this purpose, and via the use of direct participant quotes in subsequent chapters to illustrate my findings in this study. Morrow (2005) suggests additional issues to consider when assessing trustworthiness: first, subjectivity and reflexivity, which I have addressed via self-reflection, explication of my presuppositions, and consultation with a student research

group. Secondly, the issue of adequacy of data has been addressed by utilizing an appropriate sampling procedure (i.e., a purposeful sample) and by achievement of redundancy in the thematic findings (i.e., the same general themes appearing over and over again in participants' accounts of their counselling experiences), as well as by asking the participants to verify their constructed narratives prior to the analysis of the narratives. Finally, the issue of adequacy of interpretation has been addressed by several strategies: immersion in the text, articulation of the analytic framework, use of participants' actual words to show grounding of my interpretations in the participants' experiences, and reviewing the trail of my interpretive decisions with members of my supervisory committee (see Appendix D for a sample of this audit trail; while the use of such trails as tests of trustworthiness in research may have questionable validity (Cutcliffe & McKenna, 2004), it is included here to facilitate readers' comprehension of how I arrived at the findings). In addition, the issue of adequacy of interpretation has been addressed via solicitation of feedback in regard to the findings from my supervisor, supervisory committee members, and colleagues, who are experts in suicidology, counselling, and/or adolescent development, and whose feedback enriched my interpretive process and provided additional perspectives on the findings.

The following chapters present the participant narratives and the findings of this study in the form of themes and paradigm cases, which are illustrated by salient examples from the participants' narratives. The findings and their implications are then discussed in the last chapter.

CHAPTER 4: PARTICIPANT STORIES

Haven's Story

At the time of her interview, Haven was 14 years old and about to enter grade 10. She was living in Western Canada with her mother and younger sister. She was highly engaged in the interview and provided a great deal of detail in describing her experiences. During our conversation, Haven mentioned that she had been diagnosed with attention deficit disorder and also with depression, for which she was currently taking medication. Because she was outspoken and articulate, she seemed to be older than her age. The following is her story.

Haven's parents divorced when she was a young child. In elementary school, Haven moved with her mother and siblings to another city. She recalls first feeling suicidal when she entered junior high school. She believes that her suicidality resulted from not integrating socially there, particularly after she switched to a new school between grades 7 and 8.

> I came to [the new school] and I didn't really have any friends, I was kind of like a floater in there, I mean you like the one group and another group, and nobody is really connected to you or anything. I think it made me feel kind of alone; like nobody really wanted me, nobody really cared. I think that really was the main factor in thoughts that nobody would really care if I just up and disappeared.

Evident in Haven's words is a sense of disconnection with the people around her, especially a feeling of not fitting in with school peers at a particularly vulnerable time. Sometime during this period, Haven attempted suicide by impulsively taking an

overdose of medication that she had been prescribed for a sleeping problem. She could not recall exactly what had "set me off" and led to the overdose, but she guessed it might have been an argument with someone in her family. Immediately after she took the pills, Haven told her mother and was treated in the hospital. She received medical attention, but the only counselling offered seems to have been an assessment of future suicide risk (which Haven ostensibly satisfied by promising to not make another suicide attempt, which she did in order to be allowed to go home). However, she had a vague awareness that she needed additional psychological help, because she kept wondering and asking others if she "belonged in a mental hospital." Nothing else was done; the whole hospital experience seems somewhat unreal to her, almost like it never happened.

Haven's second suicidal crisis occurred approximately one year later (i.e., about a year prior to this interview). Haven believes she had "slumped back into a depression" and she now regretted telling staff at the hospital, while she was there, that she would not attempt suicide again. At one point, Haven felt particularly "on edge" due to feeling disregarded by her family, and she seriously considered taking an overdose of Tylenol. After reflecting on the pills she had counted out in front of her, she called her mother for help, who took the pills away. Haven's comments portray the inner turmoil and ambivalence that she was experiencing at this time:

> I just sat there and thought about things for, like, I don't know, half an hour, I don't even remember what I was thinking about. It's kind of like the arguing in your brain, you know, would they miss me or would they not miss me, or would they notice or would they not notice. The whole tug of war that can push you over the edge, sort of thing. Push you over or pull you back, I guess.

This "debating whether or not to" that Haven engaged in was driven by what she describes as an instinct to consider all the various options and to "save myself." The temporary ambivalence eventually ended when she made the decision to call her mother, knowing that the pills would be taken away. This was her last suicidal crisis prior to the interview.

During her young life, Haven had gone through several counselling experiences. She had seen counsellors while in elementary school to help her deal with her parents' divorce. Although this counselling took place before her suicidal ideation started, these experiences influenced her perspective on later counselling encounters. Specifically, she recalled that methods like painting and "sandbox things" worked well for her at that age, but in comparison, they seemed too childish to her when used by subsequent counsellors during her adolescence.

After her parents' divorce, Haven moved with her family to a different city. Her next counselling experience, which occurred when she was in grades 7 and 8, was in the context of family therapy and was not specifically related to her suicidality at that time. Haven formed a negative opinion of the counsellor because he seemed to be "parent-oriented" and she felt unwelcome to express her views in sessions. Haven did not find this counselling encounter to be helpful. She concluded her description of this experience by stating that "finally I just refused to go to the family sessions."

Haven also began seeing an individual counsellor for her personal problems. Haven had some difficulty remembering her experiences in detail. Family therapy and individual counselling often took place concurrently and followed a rather haphazard schedule, due in part to limitations on availability and finances. As a result, when

talking about her subsequent counsellors, Haven's recall of her general impressions was often more immediate than her recall of the counsellors' names or other specifics.

> I've seen so many therapists… who was my [next] therapist? I don't even remember her name. I really liked her a lot and we dealt with some issues, but she got in a car accident, so she was having to cancel a lot of her patients and only keep like two or three, and I was one of the ones that got cancelled.

Haven saw this counsellor briefly and was then transferred to another counsellor, whom she "hated" because she felt that the person was artificial in her demeanor and too "old" for Haven to relate to well. She talked about her experience with this counsellor, Susan (a pseudonym), at length. This description provided an example of a time when Haven found the use of play therapy methods to be inappropriate.

> Susan used to have me do sand boxes and it was okay, but it wasn't really therapy for me, like I'm not the kind of person who expresses myself [through sand play]. I would talk to my mom, and I'd be like, "I don't understand how this is helping me, because I know I have problems and obviously this therapy isn't helping me," but nobody ever changed anything.

Haven clearly felt frustrated by this counselling experience. She specifically remembered an incident in which she asked Susan to identify a particular item in the sandbox and was given a non-directive answer ("it's whatever you want it to be"); this led to her feeling angry and that she was being treated like a child. Haven also recalled that she and Susan played "these stupid games" dealing with the recognition and naming of emotions, which she found futile. Nevertheless, Haven did not share her negative impressions of the counselling process with the counsellor herself.

> I was [thinking], "I've had all these [emotional] expressions, it's not like I need to be shown and it's not like I need to discuss what they were. It was more that I need to go to the issues that caused them." … [However] I didn't really say anything, because it was better than sitting in school for an afternoon.

Not surprisingly, Haven also never told Susan about the suicidal ideation she was experiencing at this time. After a while, Susan moved out of the counselling agency and another counsellor took over the file. It was just prior to starting with the new counsellor that Haven attempted suicide by overdosing on sleeping medication. Her first session with the new counsellor was "this big, big family therapy session" which took place in a room with a one-way mirror, from behind which Haven and the new counsellor observed Haven's family discussing her suicide attempt.

> It made me feel kind of weird, but I don't think it really helped me in any specific way. It just kind of let me see how they felt about the whole thing. Then I came back in there [with my family] and we got to go over everything I had heard, which I really didn't want to do... It kind of felt like they were trying to make me feel bad, like they were trying to guilt me into something by telling me that it really hurt my family. It kind of hurt my feelings.

After this family session, Haven continued seeing the new counsellor – whom she found easier to get along with partly because the counsellor was relatively young – on an individual basis. However, this contact also lasted only a short time due to the counsellor leaving her position at the agency. This contributed to another frustrating experience for Haven, who felt that her problems were not being properly addressed, if not outright overlooked.

> She [counsellor] really didn't help me either…it was like I couldn't deal with any of my anger issues or my violent issues. I didn't have little anger outbursts [in the sessions], so she pretty much assumed that I didn't have

> those issues. That kind of aggravated me too, because she didn't look at the whole picture… [Counsellors] all assumed that there was really nothing wrong with me. They assumed that because I didn't show signs of depression, that I didn't have it.

I asked Haven how much she and this counsellor talked about her drug overdose or her suicidal ideation. She stated that they did not go into it in any detail, both because she did not understand her own reasons for the overdose, and because she "didn't want to ruin the good mood in the room" by talking about suicidality. It seems that Haven was attempting to maintain a pleasant social atmosphere in the counselling office, possibly due to misconceptions about the counselling process or due to a lack of a trusting relationship with her counsellor. Haven also felt that when she was in a good mood in the counselling session, her counsellor assumed that Haven was not depressed or suicidal and would not bring up the subject.

Haven shared other aspects of her encounters with counsellors that she found unhelpful. In fact, she felt so strongly about this issue at one point in the past that she had written out a "list of things I hated about therapists." Haven's dissatisfaction is manifest through her derisive comments.

> It seemed to me that they were doing their job with the least amount of effort they could: "So, how was your day today?" and they let you talk while they write on their little pad. I thought they were doing the worst possible job they ever could.

Haven summed up her thoughts about counselling in general by stating that she has "never really been able to talk to therapists." She usually found the session topics to be too unstructured and wanted more guidance in that regard, but she thought that counsellors are "not supposed to do that – you're not supposed to lead

the witness or whatever." Haven feels that she needed a more focused counselling approach, but based on her experiences and her beliefs about the counselling process, she did not see this as possible; this is another reason she has found counselling to be unsatisfying.

To summarize Haven's story, she experienced a great deal of distress in childhood and early adolescence following her parents' divorce and significant changes in her home and school environments. This may have contributed to her suicidal ideation, which lasted a few years and included a suicide attempt. Haven went through several short-term counselling experiences at around this time. In general, these experiences were negative; she found one counselling encounter to be particularly unhelpful and talked at length about it in the interview. Overall, Haven displayed a great deal of insight regarding her experiences of counselling.

Alicia's Story

Alicia's interview took place in her home. At the time of our meeting, Alicia was 16 years old, living in Western Canada with her mother, and preparing to enter grade 12. Her parents had divorced several years earlier. Alicia, who seemed younger than her age, tended to answer my questions in a very concrete manner and frequently became distracted, which shortened the interview considerably. She mentioned that as a young child, she had been diagnosed with "hyperactivity" for which she had taken the medication Ritalin until the start of junior high school. The following is her story.

Alicia first felt suicidal in grade 7, after her older brother was diagnosed with schizophrenia. This was a very difficult time for Alicia, compounded by the fact that her mother's time was occupied by caring for the brother. It seems that she missed her mother and wanted her own needs attended to, but felt that she was alone with no one available to help her; thus, she considered the escape that death might provide.

> I was really stressed and my mom was looking after him, and I was just really lonely. I was just always thinking about it – thinking about what it would be like if I died and went off into a different world and stuff. It was kinda scary sometimes, 'cause I didn't have anybody to look after me and talk to.

School factors contributed to the distress that Alicia was experiencing at this time. She was the victim of teasing and bullying instigated by a "popular" girl at her junior high school. The situation became so damaging that Alicia would often come home crying and eventually stopped going to school; this prompted a transfer to a different school, but "that was kinda hard too." In this stressful context, Alicia then found her brother as he was close to death after he took a nearly fatal overdose of pills; her suicidal impulses became triggered at this point.

> First, I just started cutting my wrists and stuff, and then things got worse at school. I took my mom's sleeping pills - she takes Imovane and I took like 10 of them - and then she took me to the [hospital] and they wouldn't admit me.

Alicia disclosed that subsequently to this overdose, she took several more medication overdoses that went undiscovered by anyone, including her mother. These overdoses were intended to be suicide attempts and not self-harm gestures meant to attract help or attention, because Alicia believed that she would "go to sleep and … never wake up again." Her emotional problems continued throughout junior high school; she joined a social group that shoplifted at malls, started to shoplift herself, and "got deeper and deeper." She was physically assaulted by a peer in an altercation; shortly thereafter, she took another overdose and then was admitted to the hospital.

Alicia was in the hospital for 2 weeks, which she called "the worst time ever" because of the monotonous routine and rigid structure of being an inpatient. She met with a psychiatrist a few times while in the hospital, however, she does not consider this to constitute counselling, so we did not discuss it in the interview. After being discharged from the hospital, Alicia continued to experience significant distress; she resorted to extreme measures as a cry for help, including running away and lying about being abused by her mother. When the fabricated abuse was reported to social services, counselling was arranged for the family.

It took Alicia a while to engage in the counselling process; she was "the meanest kid ever" for the first month and a half, but then she began to appreciate the counsellor's help and the experience was quite positive in the long run. In particular, she felt that the counsellor seemed to take a real interest in her – for example, by

taking her out for lunch and asking her about her hopes and dreams – and that he introduced some structure into her daily routine in the form of rules and household chores.

The counselling continued for approximately 7 months. In Alicia's view, the most helpful aspect of this experience was assisting her and her mother to "work our problems out" by talking through issues. The counsellor then left his position; another counsellor took over Alicia's file and proclaimed that Alicia was "better now," so her counselling was terminated. However, after a few weeks, Alicia felt that she wanted to talk to someone again, so her mother set up further services. This time, individual counselling was arranged through her mother's employee assistance program.

> It was okay. Just sometimes I didn't want to go and didn't want to talk. And when we'd talk, she [counsellor] would try and help me and I'd get all mad and I'd call her a shrink, and then I'd get in trouble.

Nevertheless, Alicia found this counselling experience to be quite beneficial. She explained that it was quite helpful to "talk out my problems" and to be able to relate to the counsellor due to the counsellor's young age. Alicia was not able to recount specific details of this experience. The counselling continued for several months, until financial coverage through the assistance program was depleted.

To summarize, Alicia's suicidality began in early adolescence following her problems with peers at school as well as her brother's diagnosis of schizophrenia and suicide attempt. Alicia herself made several suicide attempts, only one of which led to hospitalization. She perceived the two subsequent experiences of counselling, which involved family counselling and individual counselling, as generally helpful.

Tina's Story

At the time of her interview, Tina was 16 years old, a student in high school, and living independently in a Western Canadian city. She was quite open in sharing her experiences and I found her to be articulate and insightful beyond her age. The following is her story.

Tina had grown up in a rather chaotic family environment; when she was a child, her parents divorced and her aunt was murdered. When she was 13 years old, she acted violently toward a sibling and was placed in a group home for behaviourally disordered teenagers for a period of 8 months. She recalled that she first experienced suicidal ideation while living at this group home.

> When I first got there, a lot of people were talking about [suicide], and that's how I got to thinking about it. There were lots of people who thought about it and talked about it in group [therapy] and stuff, and I think that's how it first kind of built its way into me, and then it just took off on its own with my stuff. And so at certain times I felt like I wanted to take my life, but I'd always stop myself, 'cause I didn't want to have any pain or anything, 'cause I was such a wuss, and so I was like, "No, there's no way I can do it."

Tina's suicidal ideation came to light when her group home roommate, whom she had confided in, told one of the in-house counsellors. While at the group home, Tina took part in individual and group counselling on a daily basis. She found these counselling experiences to be beneficial, and thought that having both individual and group counselling available was particularly helpful.

> All these peers of mine who were having the same thoughts were able to talk to me about it and that helped a lot. And then if I wasn't comfortable bringing this up in group, then I could bring it up with my counsellor, and then it was kind of an ongoing circle.

Tina commented further on the beneficial aspects of the counselling she received while at the group home. She feels that it basically forced her to talk about her problems, including suicidality, "even though I wasn't quite ready to." This led her to think about the issues on her own, to write about them, and then eventually to talk about them voluntarily to her individual counsellor and in the group setting.

Tina specifically mentioned the helpfulness of the group format in counselling; in particular, she found it beneficial because it "made me see that I wasn't the only one who was going through this stuff." While she found individual counselling to be helpful as well, it felt more threatening in that it required a greater level of accountability on her part in terms of keeping her suicidal impulses in check. Specifically, she found that making no-suicide contracts with the counsellors helped her in this regard.

> With the individual counselling, it was kinda scary 'cause I felt kind of like I was disappointing them [counsellors] 'cause I started having these [suicidal] feelings. And I hate disappointing people. And so I'd make contracts with my counsellors and stuff, and if I went ahead [and engaged in suicidal acts], I would have totally disappointed them and that stopped me too.

After Tina left the group home, she attended counselling on an individual basis. Although not acutely suicidal at that time, she felt that discussing anything related to suicidality was not welcome in the counselling sessions; this began to affect the entire counselling process negatively because she became reluctant to talk to the counsellor at all, even about issues not specifically related to suicide. Eventually she found herself simply "agreeing with everything" just to placate the counsellor, at which point she knew that the counselling was no longer helping her in any way.

> So then I got another individual counsellor. And she was okay except every time I'd bring up something, like for example I have some memory loss from when I was little, and I'd bring that up, and she would be like, "Well do you really want to know what this memory loss is?" and "It could be something really horrible, do you really want to learn this stuff?" and I was to the point after I was with [the previous counsellor], I was just agreeing with what they were saying, like "Yes, uh-huh, okay!" I was pretty much just saying whatever they wanted to hear from me, so I could get out of there.

Following this negative counselling experience, Tina went with her mother and siblings to family therapy. She found this endeavour to be quite helpful due to the focus on improving communication within the family. Tina appreciated the laidback atmosphere.

> I could talk to my family about certain things that were going on and stuff that I didn't like, and the counsellor was just kinda there listening and putting things in. It was mainly my family and me talking, so that was better. [A.B.: What did the counsellor do that was helpful?] Just allowing us to talk and even if we started a fight or whatever, he would just let us talk and throw in suggestions every once in a while.

I asked Tina what her various counsellors could have done to facilitate her talking about her suicidal ideation and to make the counselling experience more beneficial. She stated that she found it helpful to express her thoughts and feelings through writing or artwork, but that this was not incorporated into her counselling (however, it is unclear if the counsellors were aware of Tina's preference). She also reported that it was sometimes difficult to remember from session to session all that had happened in the interim, which could be as long as a month, and she suggested a solution: counsellors should ask clients to audio- or video-tape their thoughts and feelings and bring in the recording to the next counselling session for discussion.

Tina found some of her counselling experiences to be unsatisfactory in other ways. For instance, she sometimes felt that she could not express her true feelings, but rather, that the counsellors were "dictating" her experiences, which she found frustrating. She also wanted counsellors to address her suicidality more directly than they were doing, and to validate her feelings to "reassure me that [suicidal ideation] wasn't wrong, that what I was feeling was okay." She felt that these aspects were missing from her counselling experiences.

Tina had several pieces of advice for counsellors working with suicidal teenagers. She suggested that counsellors bring up the subject of suicide gradually and in non-threatening ways, such as by letting the adolescent introduce session topics. However, Tina stressed that the subject of suicidality should never be ignored if the client has expressed any suicidal thoughts in the past. She related a story of a friend in the group home who talked about suicide so often that that the statements were seemingly ignored by the counsellors; tragically, this person then did commit suicide. As a result, Tina believes that all statements relating to suicide should be taken seriously.

Tina's additional advice for counsellors was centered on the interaction between the counsellor and the adolescent client. She suggested that counsellors focus their attention on the client and try to not appear distracted, because "you can totally see when someone is thinking about something other than what we're talking about." Additionally on the topic of counsellor-client interaction, Tina shared her beliefs about physical contact in counselling:

> The one thing that I didn't like at [the group home] was that the counsellors weren't allowed to touch us, and the kids weren't allowed to touch, and for me, touching is a big thing. I like hugs and stuff all the time. I realize why they did it, 'cause a lot of kids didn't want to be touched, but that was a big thing for me to adjust to. Because especially when we learned about [the friend's suicide], we really wanted to hug each other and we weren't allowed to, and the counsellors weren't allowed to, and that was really difficult. It's something that I was missing a lot.

Interestingly, Tina reported that her appraisal of the counselling she received at the group home has actually changed for the better over time. She attributes this to having reflected on her experiences, realizing that counselling really was helpful, and concluding that without the opportunity to talk to counsellors, "it probably wouldn't have turned out the way it did" – presumably meaning the outcome would have been less positive for her.

In summary, Tina first experienced suicidal ideation while living in a group home in her early adolescence, and the ideation continued for a few years. At the group home, Tina found both individual and group counselling to be very helpful. Subsequently, Tina went to several counsellors both individually and with her family, and found these experiences to be beneficial in certain respects but lacking in others. In the interview, she shared several ideas regarding how her counselling experiences could have been improved.

Simone's Story

Simone was 22 years old at the time of her interview and had recently completed a bachelor's degree from a university in Western Canada. She was living on her own and planning to travel abroad following graduation. Simone approached the interview in a straightforward and open manner; she tended to only answer direct questions without much elaboration, despite prompting. The following is her story.

Simone grew up in a family with both parents and an older sister. She did not mention any problems in early childhood. Nevertheless, she attempted suicide on two separate occasions, at ages 10 and 17, with some mild suicidal ideation in the interim. We talked about each of her suicide attempts in turn. The first attempt was triggered by an argument with her best friend in elementary school, which resulted in Simone being shunned by her classmates, who took her friend's side. She was greatly upset by this situation, and this made her want to end her life, because "I just didn't wanna deal with it anymore." Soon after, Simone found some pills in the medicine cabinet and took them, without knowing what they were. She then asked her mother about them and was taken to the hospital for treatment. Interestingly, Simone's decision to take pills as a means of suicide was based on the movie Beaches, which she had just watched and in which one of the main character takes an overdose of pills.

After this incident, Simone's family became involved in family counselling, which all members of the family attended. Her evaluation of this experience was that it was "pointless." Simone felt that her expectations of counselling were not met, because she wanted to play with the toys and dolls in the counsellor's office as she had seen done in the movies, but was not invited to do so. She also felt that she was

excluded from the counselling process because much of the time was seemingly focused on her mother's concerns.

> My mom was going through a job change then, so she hogged all the time [in the counselling sessions] and kept talking about her own problems. I was like, "Hey, I thought I was the reason we were doing this" so it didn't help at all, and I was just like, "Whatever." I wanted to talk about things and I really didn't get a chance.

Simone acknowledges that one reason for her perceived lack of involvement in the counselling sessions may have been her shyness and her tendency to answer questions with "just 'yes' and 'no'." Possibly related to this is her feeling that she did not have a choice regarding attending the sessions, and that she was just going along with the process because it was what she thought she was supposed to do.

After this family counselling ended, Simone continued to feel some mild intermittent suicidal ideation, which she attributes to "teenage angst." She was prescribed antidepressant medication and did not attend counselling during this time. Taking the antidepressants seemed like a quick fix to Simone and therefore, she saw it as very different from the process of counselling; as a result of this juxtaposition, she felt disillusioned and wished that counselling could work as quickly as medication may be able to do.

> You feel like someone should be able to tell you what's wrong and how to fix it. Like with the pills they gave me, "Oh, now everything will be fine." That's why I think the pills are kind of a dumb idea – [because] then having the counselling and having that not be a quick fix, kind of didn't work together, like a mixed message in a way.

At the age of 17, Simone went on a trip to another town with some friends who wanted to find drugs there, which bothered her because she was opposed to drug use. In addition, she did not get home until past her curfew that night and had an argument about that with her mother. As she was already feeling stress due to the situation with her friends, this argument was "the straw that broke the camel's back." Simone took an overdose of Tylenol, her mother discovered the suicide attempt, and took Simone to the hospital for treatment. Her mother then made an appointment for Simone to see a psychologist.

Simone had mixed feelings about this counselling experience; she called it "momentarily helpful." She felt it was better than her previous counselling experience because this time was individual counselling, and she appreciated the opportunity to talk. In particular, she liked being able to decide the session topics and to talk about the same subjects repeatedly if she wished to do so, which she felt she could not do with other people in her life. The sessions were focused on the factors contributing to Simone's being "unhappy" such as her shyness, rather than suicidality per se. While she found it helpful to have someone to talk to about her problems, Simone believes that "in the long range, it was actually myself that kinda figured out why I was wanting to kill myself all the time and realizing why I didn't [commit suicide]." Therefore, in her opinion, this counselling was only indirectly helpful at best.

Simone recounted some of the aspects of this counselling experience that she found to be negative. One was being asked by the counsellor to draw pictures, which she did not find appropriate for her age (however, she persisted at the drawing task because she assumed that the counsellor, as an expert, had a good reason for asking

her to do it). Another negative aspect was the counsellor's office décor, which she found too feminine and "weird." Simone also expressed her dissatisfaction with a specific approach that the counsellor employed.

> I had my problem with shyness and then she got this book about how Carol Burnett used to be shy. It felt like the psychologist was just kind of grasping at things that she didn't really understand, like she didn't really understand the shyness maybe, and how much that affected me.

Despite these various criticisms, Simone still found her counselling experience generally helpful; she liked being able to talk to the counsellor, who mainly "just kind of listened". Not surprisingly, Simone's advice to counsellors working with suicidal adolescents was that "it just takes time and listening, that's all." However, she believes that honest and open interaction was missing to some degree from both of her counselling experiences.

> A lot of times I would just give the answers I knew they [counsellors] wanted; they were like, "Have you had any suicidal thoughts?" and I'd be like, "No," even if I had. Adolescents know what's expected when they are asked direct questions like that.

When asked to elaborate on this, Simone reported that she would often say things she thought she was supposed to say in counselling in order to please her mother and her counsellor (whom she wanted to reassure of having done "a good job"), and also because it was the "easy" thing to do. She suggested that counsellors use open-ended rather than closed questions to encourage adolescents to talk more freely in counselling.

Finally, Simone observed that during her adolescence, her suicidality and subsequent involvement in counselling were considered by her family to be shameful secrets, but that when she entered university, it became "cool to appear tortured" and going to counselling was a status symbol. This shift in perception occurred after she had already completed counselling.

In summary, Simone had two counselling experiences, each following her medication overdoses at ages 10 and 17. The first counselling encounter, which was in the context of family therapy, was largely unhelpful, as Simone felt overlooked in the sessions and did not do what she had expected to do in counselling (i.e., play with dolls). Her second counselling experience was more beneficial, because she felt able to talk about her problems in a somewhat open manner. However, this encounter was still unsatisfactory in several ways. Simone believes that she overcame her suicidality mainly on her own, rather than via counselling.

Matt's Story

At the time of his interview, Matt was 24 years old and looking for work. He reported that as a child, he lived for several years in another country where his parents were wealthy expatriates, before he moved back to Canada alone to attend boarding school. He then completed some post-secondary education in Eastern Canada and had moved out West a few years prior to our meeting. In the interview, I found Matt to be extremely open and enthusiastic about discussing his experiences. The following is his story.

Matt reported that he first felt suicidal in high school, however, initially, he did not consider this to be important in the context of the interview, because "nothing happened" – he did not actually attempt suicide, although he did have a plan, which got thwarted. He said he first learned of specific methods to commit suicide in a high school class in which "they tell you about the ways that people usually do it, and I knew from that class that if I took enough Tylenol it would kill me."

At this time, Matt was at boarding school, feeling isolated and abandoned by his parents, who were living in another country. His suicidal impulses took Matt by surprise; it was a "shush, shush thing" that happened in "everybody else's family." He was planning to kill himself with Tylenol; then, possibly as a cry for help, he asked the school nurse about its lethal dose, which resulted in his dormitory room being searched. Matt's intentions were uncovered when his stockpile of pills was found.

The school nurse contacted the school counsellor, who arranged appointments with Matt. He found the sessions to be simultaneously helpful and unhelpful; while he

views this counselling in negative terms (with contempt, even), the experience allowed him to see himself in a more positive light, which made him feel better.

> He [counsellor] wasn't good, actually I might even say he sucked. [But] it was good because it was so bad; bad enough for me to be aware that he was bad, that it made me realize, you know, how strong I was as a person, and how powerful I was over my own life. … It was good because I could see that he was wrong - well, not wrong, but he wasn't going in-depth enough with me, and it made me feel good because I knew better than him, and that was like chocolate for the soul!

When asked to recall what he felt he had gained from these counselling sessions, Matt could only say, "Time off class." He believes that the counsellor was using a very generic approach to working with clients, because he had overheard a classmate talking about her sessions with the same counsellor and they sounded eerily similar in content to Matt's counselling sessions. Thus, this counselling overall was not a positive experience for him.

The counselling stopped when the academic year ended. Matt graduated from high school and then moved to another city to go to college. While he was no longer suicidal at this time, the move was a difficult transition for him in several ways.

> I was going from a boarding school where I knew everybody in a small town, and then I went to college in another city, having my own apartment, and new school. I was going to college because my dad told me to go to college. But I had no clue whatsoever what I was doing [there]. When I graduated, I wanted to take a break so I could figure out where I was going. But oh, no, no, no, that was impossible… So I went.

Matt struggled academically, failing several courses. After his first year at college, his parents found out that he had been suspended from school for academic reasons and Matt "hit rock bottom." He described his parents' reaction as extremely

angry. This was the culmination of several long-standing problems with his parents; Matt said that he had always felt disconnected from them and "on top of everything, I'm gay," which they did not accept.

At this point, Matt again experienced suicidal ideation, which progressed to action when he took an overdose of Tylenol. Matt's mother discovered the attempt and he was taken to the hospital. He stayed there for three days; his psychiatrist wanted Matt to stay longer, but his parents did not want him to miss the start of the next academic year. Matt experienced his brief interaction with the psychiatrist at the hospital as helpful, because he felt that the doctor treated him like a person worthy of his time and respect, something that Matt had not experienced elsewhere or with his parents. He also found it helpful that, "as stupid as it may sound," he felt that there was an unspoken bond between him and the psychiatrist, because they were each in his own way being pressured by Matt's parents and this led to a sense of camaraderie in the counselling sessions.

When Matt returned to college, now enrolled in a different academic program, he disclosed his continuing distress to an instructor whom he felt close to; this person then helped him to find a psychologist. Matt stated quite emphatically how positive this counselling experience turned out to be: "I think it was the greatest thing since sliced bread." Several factors contributed to this very positive experience. The counsellor's willingness to listen and give credit to Matt's strengths made a particularly big impression on Matt.

> She made me feel like she believed in me, saying, "You have a brain, and you can use it, and I know you will". … She destroyed everything I had, and I think it's the best thing ever. [A.B.: What do you mean, she destroyed…?]

> Because see, I had parents, an apartment, and a school I didn't like… she took all that away from me, and then she said, "Well, what are you going to do now?". Or maybe, not taking them away from me, but she flipped me around so I couldn't see them anymore.

This counsellor encouraged Matt to take more responsibility for his own life and to move psychologically away from his parents, who he felt put him "in a cage." Matt was encouraged to consider the possibility of not doing everything his parents wanted, which he found quite liberating. In addition, Matt appreciated the clarity of the counselling goals that were set, and the fact that the counsellor was quite directive in their work together.

At one point, Matt's mother requested a meeting with this counsellor, presumably to discuss Matt's situation. The counsellor asked Matt how he felt about this – "I think it was the first time that somebody asked me about how I felt about something" – and while he was not entirely comfortable, he agreed to the meeting in order to appease his mother. The counsellor met with Matt's mother but did not divulge any details about him or his counselling, which pleased Matt very much; it also allowed him to further consider separating from his parents' influence.

Matt pointed to the counsellor's young age as being beneficial, because he felt that she could relate to him better because of it. (However, Matt also acknowledged that the age of the counsellor is less important than the client's comfort level and connection with the counsellor.) Even when prompted, Matt was not able to identify any negative or unhelpful aspects to this counselling. When asked about any advice he might have for counsellors working with suicidal adolescents, Matt made some suggestions based on his own experiences.

> I would say try not to change them, but help them become what they have inside. A good therapist for a teenager should be able to make the teenager realize the truth they have inside. [A.B.: How do you think a therapist could do that?] By, well, exactly how my therapist did it! Asking me what I like, what I'd like to do, how I would do it, and then to tell me to do it. She asked me, "What part of Matt has never been used?".

In summary, Matt first experienced suicidal ideation in high school. He found going to the school counsellor to be unhelpful, but interestingly, it also made him feel better, seemingly due to the emergent awareness of his own strengths and values as a result of the encounter. Matt's second bout with suicidality occurred a few years later while he was attending college. He met with a psychiatrist and later, a psychologist; he found both of these counselling experiences to be tremendously helpful, and he was able to share in the interview a great deal of his insight regarding what made them so.

CHAPTER 5: FINDINGS

This chapter presents my findings in two sections. The first part reports the themes and subthemes that were identified via thematic analysis, along with relevant illustrative exemplars. The second part explores two distinct paradigm cases that convey additional salient information with regard to participants' counselling experiences following adolescent suicidality.

Thematic Analysis

Five themes were identified in the participant narratives using an inductive method of analysis based on Merriam (2002). The themes deal with topics that the participants explicitly addressed in their interviews, rather than with latent meanings. The themes were named following an exploration of commonalities and differences among the topics discussed by participants and finding the best fit for these topics in terms of categorization into theme groupings. The themes and their corresponding subthemes are illustrated with exemplars in the form of direct participant quotes. A summary of the themes is presented later in this chapter, as is their synthesis with the forthcoming paradigm cases. For reference purposes, a tabular representation of the thematic analysis results is provided in Appendix E.

Theme 1: Appreciating Counsellor Openness

A major theme that emerged from the participants' narratives centers on their appreciation of a particular interpersonal style on the part of counsellors, which I have labeled as openness and which was characterized by three key qualities: attentiveness, respectfulness, and genuineness. These qualities generally contributed to a positive

counselling experience if they were judged by participants to be present; conversely, the perceived absence of such qualities often contributed to a negative experience. Each of these counsellor qualities is discussed below.

Valuing counsellor attentiveness: "I just wanted to talk and have people listen."

One quality that resonated strongly in the narratives was attentiveness, characterized by counsellors' focusing on and listening to the adolescent in the counselling session. Alicia, Simone, and Matt reported that their counsellors had demonstrated attentiveness and they found this to be beneficial in their counselling.

> We'd just talk... He [counsellor] would ask me what I'm going to do when I get out of school and stuff like that. I thought it was cool. … He just helped me talk out my problems, asked me what was bothering me, asked me stuff. (Alicia)
>
> I just wanted to talk and have people listen. I used to talk to my best friend and she was like, "You drive me crazy, I can't handle all your problems all the time" [but] with the psychologist, I could just talk about whatever I wanted to, and I could talk about something again and again. … She [counsellor] didn't really give suggestions or ask questions, just kind of listened. (Simone)
>
> She [counsellor] did what my parents never did: she listened to me. (Matt)

On the basis of the first two comments, counsellors' attentiveness had the crucial role of facilitating communication and in particular, participants' expression of distress. An ability to focus on what the adolescent viewed as important and an accommodating attitude toward the topics in counselling sessions – regardless of those topics' relation to the problems which brought the teenager to counselling – appeared to allow the participants to feel free to discuss those very problems. Such factors seemed to lead participants to perceive the counselling as helpful.

However, participants did not perceive their counsellors as attentive in every encounter. A lack of attentiveness was felt to be a negative experience in counselling, as demonstrated by the following piece of advice offered by Tina to any counsellor working with suicidal teenagers, which she based on her own bad experience.

> Try to make sure you're focused on that one person, and not thinking about a whole lot of other stuff at that same time, 'cause we [clients] can see that! [A.B.: How did you see it?] She [counsellor] would look around at other things or look down at her papers, and you'd think she's writing but you can see the little doodles she's doing. … [Suicidal adolescents] have to know that they [counsellors] are listening and be able to see it. (Tina)

Delving further into counsellor attentiveness, counsellors' willingness to let clients talk about problems and to listen with sustained attention conveyed a sense of caring. For instance, Matt had a highly positive counselling experience due at least in part to the counsellor's clear display of attentiveness; his comment above juxtaposes this experience with what he seemed to crave from his parents, namely, attention and caring. On the other hand, Tina's counselling encounter appeared to lack such a sense of caring due to the counsellor's seeming inattentiveness, and was considered by Tina to be an unhelpful experience. In general, participants valued counsellor attentiveness demonstrated by the kind of sustained, patient, and supportive listening that Simone alluded to in her comment above.

Valuing counsellor respectfulness: "We're on the same level here."

This counsellor characteristic encompassed an attitude of respect for the adolescent client's privacy, point of view, and sense of autonomy. When it was felt by participants to be present in counselling encounters, this respect conveyed to them that their counsellors considered them to be important and capable individuals, which

naturally contributed to their having positive counselling experiences. Tina and Matt recounted specific instances in which they felt that their counsellors were respectful toward them.

> They [counsellors at the group home] always made sure that there were just the two of us and there wasn't any distractions, and they made sure that the other counsellors knew that we were going to talk, so they didn't interrupt us. (Tina)

Matt appreciated that his counsellor respected his privacy – in his case, by not divulging details of his counselling sessions to his mother. With another counsellor, the counsellor's verbal and nonverbal behaviour communicated to Matt a sense of respect for him as a person.

> He [counsellor] shook my hand, and he said, "It would be nice if you could look in my eyes, you know," and oh! – that was like, that was the beginning of a new life there. [A.B.: What message did that give you when he said that?] You know, "If you respected yourself you would look at me, you would look me in the eyes." I felt like, well, he's respecting himself, he's respecting [me], I respect myself – we're on the same level here. (Matt)

It seems that if the counsellor deemed him to be worthy of respect, then Matt felt that he was indeed deserving of it, not just from others but from himself as well. With another counsellor, Matt experienced respect for his beliefs and abilities, which allowed him to see himself in a new light.

> It was the first time that somebody asked me about how I felt about something. … For the first time of my life I had somebody telling me that parents do not always know best, and that I had a brain, and that I wasn't going to end up living in a dumpster under a bridge. (Matt)

On the other hand, some participants felt that respect was missing from a few of their counselling encounters, which they perceived as negative experiences. For instance, Tina found it frustrating when her counsellor discounted topics that Tina wanted to bring up in counselling sessions (e.g., childhood memory loss), and she interpreted this as a lack of respect for what she considered important. Haven and Simone both reported analogous experiences.

> I couldn't stand him [family counsellor]. All of his opinions were parent-oriented, and he didn't believe that children had any right in anything, any say in anything. I'm like, "No, that's not right. I have a right to voice my opinion just as much as [my mother] has a right to voice her opinion." (Haven)

> They [counsellors] were always asking me if this [suicidality] was revenge on my mom or something like that, but that's not what I felt it was at that time … I was thinking, "Who are you to say it was that shallow!" So yeah, that really bothered me. 'Cause they kept coming back to that, and I was like, "No! That's not it!" (Simone)

These participants felt that some counsellors did not respect their viewpoints, and this made for frustrating counselling experiences. Furthermore, they interpreted the seeming lack of respect as a devaluation of their personal worth or character; both Simone and Haven perceived it as a personal affront when counsellors misunderstood or ignored their points of view. Tina also experienced a lack of counsellor respect for her views in one of her counselling encounters, and echoed the frustration manifest in the above comments, as well as her feeling of helplessness and futility in counselling.

> I felt that I wasn't allowed to be me – that I was supposed to just go along with what they [counsellors] were saying and not really challenge them at all. It was kinda like they were dictating what I was feeling, what I was trying to get across, and even as hard as I tried to explain it, they never quite got it, and I don't really know how to explain it better to make them understand. (Tina)

Overall, an attitude of respect on the part of counsellors conveyed to the participants that their personal worth and abilities were recognized and validated, which in turn allowed their self-respect to flourish. These were obviously positive counselling experiences. Conversely, a perceived lack of respect in counselling frustrated and offended the participants, leading to negative experiences.

Valuing counsellor genuineness: "What are they writing about me?".

In contrast to the two counsellor characteristics discussed thus far, participants did not explicitly identify the presence of this characteristic – counsellor genuineness – as a positive factor in their counselling experiences; rather, only its absence made an impression upon the participants. Genuineness refers here to transparency of the self in counselling sessions as well as authenticity of felt reactions in the sessions (demonstrated by, for example, counsellors' open expression of their personality). Haven described several counselling encounters in which counsellor genuineness seemed to be lacking.

> I hated her [counsellor]! She was one of those really, really happy people who always has a smile planted on their face whether or not they really mean it, and that really aggravates me. (Haven)

Haven found that counsellors' note taking during sessions seemed suspect, because "they'd never let me read [the case notes] and I don't know whether they're supposed to or not, but like, what are they writing about me?". The clandestine nature of note taking may have indicated to her a lack of counsellor genuineness; her advice to counsellors was to discuss their case notes with clients at the end of each session. Another participant's comment also reflects a desire for counsellor genuineness.

> I wouldn't like a therapist that acts like a teenager. I don't think I would enjoy having my therapist dress up as Britney Spears. [A.B.: So, don't be fake? Is that what you're saying?] Exactly. (Matt)

Accordingly, Matt's advice to counsellors working with suicidal adolescents was to "not to try to act cool." Thus, he saw counsellor genuineness as being true to one's self as opposed to pretending to be whatever society – or adolescent culture – considers popular. Given that the participants may have been highly attuned to any signs of hypocrisy in other people's behaviour, as many adolescents tend to be, it is not surprising that they yearned for genuineness in their counselling encounters, and found any seeming lack of counsellor genuineness to be abhorrent.

Counsellor genuineness was generally linked with positive feelings toward counsellors on the part of the participants. Interestingly, however, Haven expected a helpful counsellor to be genuine but also a person that she would not necessarily like. This is exemplified by her preference for a counsellor who "rubs you the wrong way" and is able to challenge and confront the client, instead of repeating platitudes like, "That's okay, I understand." She expanded on this idea:

> For some reason, in order for me to make any progress [in counselling] it has to be with somebody who can just push the buttons and watch the reaction and not be offended by it. 'Cause those [counsellors] who smile at you all the time and just say what you want to hear, they don't do that. (Haven)

While participants appreciated counsellor genuineness, this did not translate into wanting self-disclosure on the part of the counsellor. In fact, knowing too much personal information about the counsellor was specifically portrayed as undesirable. For instance, Simone noted that the décor of her counsellor's office "seemed a little

too personal, like it showed a lot about her" which she found disconcerting, and Matt thought it was helpful in his counselling encounter that he "knew nothing about [the counsellor's] personal life, and it was really all about me."

Generally, in the felt absence of counsellor genuineness, a superficial and unhelpful counselling experience remained, as shown by Haven's earlier comments. Interestingly, participants' wish for greater counsellor genuineness did not translate into a wish for counsellor self-disclosure, the latter being perceived as undesirable. Overall, when participants believed that counsellor genuineness was lacking or that undue counsellor self-disclosure had occurred, they were likely to see the counselling experience more negatively.

Theme 2: Needing Direction

The second theme identified in participants' narratives is focused on their expressed need for a sense of direction in counselling. When counsellors utilized an active and goal-focused approach, participants were likely to view the counselling experience as beneficial. This theme consists of two components: the felt need for delineation of goals and for guidance of session topics, as described below.

Needing delineation of goals: "'If we go step by step, we'll get there in no time'."

This subtheme relates to participants' view of counsellors' practice of setting goals for the counselling endeavour or for the adolescent client's daily life as critical. Participants viewed setting goals as a unilateral process rather than a collaborative effort between the counsellor and the adolescent; the implication is that the counsellor would take an active role in goal setting while the adolescent client would comply.

Both Matt and Alicia reported that they found it helpful when counsellors delineated goals in this way.

> The counsellor set out the counselling goals clearly. She would say, "Well, this is where we're going to go. Okay, it might sound crazy right now, but if we go step by step, we'll get there in no time." [A.B.: And you appreciated that, to have a plan like that?] Yes. (Matt)

The counsellor's practice of goal setting was beneficial to Matt because it helped him to understand the counselling process. Furthermore, Matt liked that the counsellor broke down the overall goal into smaller steps that seemed attainable, thus increasing his motivation to engage in counselling. Thus, in addition to demystifying the process of counselling, goal setting may have decreased any ambivalence on his part related to undergoing change in counselling.

Secondly, Alicia described a counselling experience in which the counsellor set some goals for her daily life, which may have been missing at that point in time due to the fact that her mother was preoccupied with caring for Alicia's ill brother. The goals set out for Alicia included observing a curfew and doing household chores; while it is perhaps unusual for an adolescent to like having such objectives imposed upon her, Alicia viewed it as a helpful intervention. However, it must be noted that even though she saw the overall experience as positive, she did not always welcome the counsellor's direct approach, due to the consequences if she did not comply with the counsellor's instructions.

> Well, sometimes I didn't want to listen and I wanted to go watch TV and he'd make me sit there. And if I didn't listen, he wouldn't talk to me and stuff. (Alicia)

Therefore, the delineation of goals by counsellors not only laid a framework for the process of counselling, but also introduced needed structure into participants' lives. Matt and Alicia appreciated counsellors who used goal-oriented and structured approaches. On the other hand, Haven talked about a particular experience in her encounter with the counsellor Susan that seemed to lack a clear sense of direction.

> I was going to work with a sand box one time and I picked something up, and I just asked her what it was and she said, "It's whatever you want it to be," and I just exploded, because I can't stand it when people tell me that. Because it's something [and] I just wanted to know what it was. (Haven)

Haven stated that the non-directive nature of this experience "drove me nuts." While the experience was not directly related to goal setting, her comments speak to her desire for direction in counselling sessions.

Needing guidance of session topics: "I'm the kind of person that has to be led."

Another aspect of participants' need for direction in counselling is their expressed desire for guidance of session topics by counsellors. Tina and Haven both experienced a lack of direction in this regard and as a result, felt that their counselling was impacted negatively.

> I felt like I was the one doing all the talking, she [counsellor] wasn't even asking me anything and I have a problem with that, so it was hard for me to talk with her. (Tina)

> I'm not the kind of person that just takes whatever you say and says it back to you. I'm the kind of person who likes to have questions asked of me, and then I can give detailed answers, instead of have the person say, "Okay, so what do you want to talk about today?" and then have me go on and on. I can't do that! If they [counsellors] don't really address the issues, I can't bring it up myself. … I'm the kind of person that has to be led. (Haven)

Both of these participants referred to the importance of counsellors' asking questions that were relevant and detailed enough to allow thorough exploration of the subject matter. Through asking questions, the counsellors directed the topics in the sessions, thus guiding the clients toward the expression and resolution of problems. Simone talked specifically about counsellors' use of open questions in sessions; she reflected on the value of such questions in eliciting the client's inner experiences.

> I think [if the counsellor were to use] open questions, that's hard to lie, you just kinda have to say what you're thinking or feeling. [But with closed questions] it's so easy to lie and say what they want to hear. (Simone)

According to Haven, however, it is not sufficient for counsellors to use any open questions; the questions should also be focused rather than vague, in order to engage the adolescent client and to guide the discussion in a helpful direction.

> They [counsellors] sit there and they ask you questions, but they aren't really detailed questions, just "How was your week?" or "Have you had any major things happening or anything like that?". I'm just like, "No, no, no, no." … I need to have someone say, "So what is it that really bothers you about your sister?" or whatever. (Haven)

Thus, both Simone and Haven spoke about their tendency to conceal or outright lie about their experiences when asked closed or unfocused questions in counselling sessions. Participants may have interpreted such questions as a lack of understanding or a lack of effort to engage on the part of the counsellor, and this in turn may have decreased their willingness to be forthright. Haven's derisive remark that counsellors who asked her vague questions were "doing the worst possible job they ever could" captures the frustration engendered by such counselling encounters.

Theme 3: Feeling Unattended to as an Individual

The third theme that emerged from participants' narratives deals with their perception of certain approaches used by counsellors – or perhaps of the counsellors themselves – as lacking in attention to the participants' individual needs. Specifically, participants reported that some of their counselling experiences seemed unresponsive to their needs due to an apparent lack of flexibility or adaptability in the methods, or due to their inappropriateness given a participant's developmental level, as described below. Participants also had several suggestions for how to remedy the problems that they perceived in the realm of responsiveness.

Feeling pigeonholed: "He was putting me in a big melting pot with all teenagers. Well, I wasn't all teenagers."

To pigeonhole means to assign to a particular category in a rigid or restrictive fashion, thus, to be pigeonholed means to be categorized stereotypically or inflexibly; there is a sense of fixedness in the outcome. Feeling pigeonholed in the context of the present theme was related to a lack of adaptability of counselling interventions to the needs and desires of the individual client. This lack was experienced by some of the participants in their counselling encounters; Haven in particular reported that she perceived a lack of flexibility in the techniques employed by her counsellor. Consequently, she found this encounter to be unhelpful.

> They [counsellors] have to be willing to change and shift for you as a person because not everybody is the same, you can't just use the same exact method on every single person. You really have to be flexible about what methods you use... Mostly what I had a problem with was their methods. Susan's method was to do sand boxes. Once she discovered that it didn't get to the root of my problem, she should have found a different way of doing things. (Haven)

Furthermore, Matt and Tina suggested that counselling should be more flexible in terms of the time allotted to sessions and the management of information during the time intervals between sessions. They seemed to want to get as much as possible out of their counselling, and they did not like it when information got missed or forgotten in sessions due to lack of flexibility in the time structure of counselling. Tina also thought that recording the relevant information in some way between sessions would increase the benefits of counselling.

> [A good idea is] not having a timer; after 45 minutes of session, allow a bit more time because, well, I would go out [of the counselling session], I would get to the subway station, and then I would say, "Oh! I should have told her this!" so I had to write it down [for the next session]. (Matt)

> With the [monthly sessions], they [counsellors] were like, "Okay, what happened at the beginning of the month?" and you're like trying to remember. It would be helpful to record that information using a tape recorder or a video camera so that they could see what kinds of things are going on right then, so they could see how you're feeling right at that moment. (Tina)

The idea of flexibility also came up in the context of catering interventions to fit the individual client. Matt and Tina felt that their preferences and needs were not taken into consideration in counselling. Specifically, Matt felt pigeonholed because the counsellor treated him like a generic adolescent, rather than as a unique individual.

> He [counsellor] was, like, doing mass production there: we were all wearing the same [school] uniform, well, we were all seeing the same psychologist, and it was all the same thing. … We were all getting the same treatment, like, me being suicidal, the other one being beat up by his parents, and the other one had no self-esteem, we were all getting the same thing. … He was putting me in a big melting pot with all teenagers. Well, I wasn't all teenagers. (Matt)

Tina knew that she typically found psychological benefit from expressing her inner experiences via creative or artistic methods, yet these were not incorporated into her counselling sessions. While it is not clear if the counsellor was aware of Tina's preferences, she felt the counselling was not flexible enough to accommodate her needs which decreased the value of the counselling in her eyes.

> I was either writing it down or drawing pictures or [listening to] some piece of music that really affected me, and to be able to bring it in or listen to it or talk about it or something like that would have been really helpful. (Tina)

The above comments reflect the importance that participants placed on being viewed and treated as unique individuals. If this was felt to be lacking in counselling, they may have concluded that they were not important enough for the counsellor to make the effort of catering techniques to their needs. In other words, perception of inflexibility in counselling meant that participants viewed the interactions as generic and themselves as pigeonholed and thus seemingly unimportant.

Feeling disregarded: "I was 12 years old and that's old enough to not be playing in the sand."

Another component in participants' stories that relates to their perception of counselling as unresponsive to their individual needs is a feeling of being disregarded in terms of developmental level. Some participants specifically commented on their perception of a lack of age-appropriateness in the interventions used in counselling; the counselling seemed inappropriate to them because they felt it was geared toward young children. Such counselling experiences were quite obviously negative ones.

For example, Haven mentioned the play-based counselling that she took part in both before and during her adolescent years, and contrasted these two experiences.

> It was the child kind of therapy; we painted and did sandbox things and all that. It was okay because that's how old I was, like it was the right thing [for that age], but then the fact the rest of the therapists [a few years later] did the same thing, really drove me nuts. … I was 12 years old and that's old enough to me to not be playing in the sand. (Haven)

In regard to another approach employed in counselling when she was in her early adolescence, Haven stated that it was "kind of like a childish game that I didn't really go for." Again, she felt that some of the methods used by counsellors were not geared to her age; this diminished the counselling experience in her eyes. Likewise, when Simone reflected on one counselling experience in her adolescence, she came to a similar conclusion: she thought that being asked by the counsellor to draw pictures was "pretty lame." On the other hand, when Simone attended counselling as a child, she felt that a method which she saw as age-appropriate was not available to her.

> They had toys in the room that I always wanted to play with, but I was too old to kind of get to do that. You know how you see in the movies where they always get to play with dolls and everything. (Simone)

To sum up, Haven and Simone perceived certain methods to be lacking in age-appropriateness. They expected to engage in play-based counselling approaches in childhood, but to do something different and more sophisticated as teenagers; this may be based on adolescents' general desire to be viewed as mature and distinct from children. However, it should be noted that one of the participants did not experience play-based methods in counselling during her teenage years as inappropriate.

> She had play-dough, and she told me to make things out of play-dough and stuff. That was pretty cool. (Alicia)

Alicia seemed in the interview to be younger than her chronological age, whereas the other participants did not. Therefore, developmental level may be more important than actual age in terms of gauging the appropriateness of a given method. This idea reiterates the message of the previous subtheme, namely, the value that the participants placed on the incorporation of flexibility and adaptability in counselling with the goal of meeting their individual needs.

It is possible that participants who reacted negatively to the use of sand play and drawing in counselling did not understand the intent of the counsellor's approach and misinterpreted it as a "game" aimed at young children. This is demonstrated by Simone's mocking comment about a counsellor's having "made me draw pictures of a happy place and pictures of a sad place" which, at the age of 17, had offended her. An explanation of the counselling process as a whole and the purpose of particular approaches utilized by the counsellor may have averted such negative outcomes for the participants; this corresponds to an earlier subtheme reflecting that participants found delineation of goals in counselling to be important as an educative strategy.

Theme 4: Yearning for a Relational Climate

The fourth theme identified in participants' narratives deals with their desire for a comfortable, warm atmosphere in counselling that is conducive to interaction, which I have labeled as a relational climate. This theme encompasses participants' preference for counsellors who are attuned to the adolescent culture as well as their desire for a welcoming counselling setting. Each of these ideas is discussed below.

Wanting a counsellor attuned to adolescent culture: "I would tell her about things that teenagers know and like."

Some of the participants mentioned or alluded to the age of their counsellors when describing their counselling experiences. For instance, Haven implied that the counsellor's age was an important aspect when she said of a counsellor whom she found helpful that "she was really young and I really got along with her well" and characterized a counsellor whom she did not find helpful as "really old". It appears that the age of the counsellor in relation to that of the participant was an important factor in determining the participants' comfort level in counselling; Alicia's and Matt's comments describing positive counselling experiences echo this idea.

> …because she [counsellor] was like really young, she was about in her 20s, early 20s, and she could [relate] to the kind of stuff that I was talking about. (Alicia)

> It was nice because she [counsellor] was young. I was comfortable with her; she was just a bit older than myself. She knew about the bars, I would tell her about things that, you know, teenagers know and like. (Matt)

It seems, therefore, that when the age of the counsellor was perceived by participants as being relatively close to their own age, they felt more comfortable in counselling that they would with an older counsellor. (However, Matt acknowledged that one's overall comfort level is more important than the counsellor's age per se.) Proximity in age promoted a positive counselling experience, due to the participants' willingness to share their thoughts and feelings with someone who put them at ease, rather than with someone with whom they felt tense or awkward.

The preference for relatively young counsellors reflects participants' appraisal of such counsellors as better able than older counsellors to understand and join with adolescent culture. In cases where counsellors were perceived as "old," participants may have viewed them as being part of their parents' generation and thus less able to identify with youth. For participants, this may have acted as somewhat of a deterrent to building a connection with the counsellor and likely diminished their experience of counselling. Interestingly, while participants preferred counsellors who were close to them in age – akin to a friend or a peer attuned to the adolescent culture – they also wanted counsellors to take on a relatively directive, somewhat parental, role as was described earlier in the second theme. This juxtaposition will be discussed in the last chapter.

Wanting a suitable physical environment: "Just make sure you're inviting."

This subtheme deals with the physical setting in which counselling took place. The setting either facilitated or hindered the participants' experiences in counselling. Simone and Tina indirectly commented on the suitability of the counselling setting, by recalling negative encounters in this regard and by offering advice to counsellors working with suicidal adolescents.

> She [counsellor] had this white wicker furniture with flowery cushions and stuff, and looking back it was really a weird atmosphere 'cause it was so white, it was just really girly and happy. (Simone)

> Just make sure you're inviting; I always thought you should have a counselling session where you sit down, have a cup of coffee or tea or something like that. In a room that's not sterile, it should be brightly coloured. (Tina)

Expanding on this idea, Tina suggested that counsellors working with adolescents use offices dedicated specifically to that age group that do not contain "little kids' stuff." Therefore, participants again seemed to want to feel that they were seen as distinct from young children and invited to interact with the counsellor on a more mature level. Simone's above comment reflects the importance of the perceived mood in the counselling setting; in her case, the "happy" décor was incongruent with what she expected counselling to feel like. This may have negatively affected her connection with her counsellor, because she stated that "in the long range, it was actually myself that kinda figured out why I was wanting to kill myself all the time and realizing why I didn't," so the counselling seems to have had a relatively minor role. Finally, while Alicia did not directly comment on the physical environment of counselling, her positive evaluation of one of her counselling experiences may have been influenced by the fact that the counsellor came to Alicia's house for the sessions and occasionally took her out for lunch, both of which were presumably well-suited settings for her. In sum, a sense of comfort in the physical environment of counselling was desired by participants as it was seen to facilitate communication and connection with counsellors.

Theme 5: Wishing that Counsellors Would "Reroute" the Topic of Suicidality

The final theme that emerged from participants' narratives is related to their frequent mention in the interviews of how the topic of suicidality should or should not be addressed in counselling sessions. Participants often talked about the importance of proceeding indirectly into this topic. They also expressed a desire for being put at ease prior to and during discussions of suicidality, which may have been a reaction to

the undoubtedly stressful experience of addressing this topic with families, friends, or medical professionals. They wanted a calm and safe place to discuss their suicidality and looked for this opportunity to present itself in counselling.

Participants freely gave advice to counsellors regarding addressing the topic of suicidality in counselling sessions, based on their experiences therein.

> Don't pressure them about it [suicidality], just let them talk, like talk to them about their family or ask them what's bothering them and stuff. Let them open up to you; don't make them talk about it. [A.B.: Did you find that your counsellors did that with you, or did they sort of force it sometimes?] They kind of forced it sometimes, they were always like, "Why would you want to kill yourself, what's the point of that?" and stuff like that. (Alicia)

> Go in the direction that they want to, don't try to force them to go there [topic of suicidality] if they don't want to, it just kind of makes us not want to talk about it even more. Let us talk about the things we want to and then kind of reroute it that way or something. (Tina)

Therefore, Tina and Alicia expressed a preference for having the topic of suicidality addressed in an indirect way, without being forced or criticized, in which they were given the lead in introducing the topic when they were ready to discuss it with the counsellor. Simone felt that this was achieved in a counselling encounter which she viewed as helpful, and which she summarized as: "We talked a lot about my shyness and stuff like that, not so much about me being suicidal or whatever, just what was making me unhappy." However, despite the merit of an indirect approach to discussing suicidality, Tina emphasized that this topic should be directly addressed once the adolescent brings it up; she came to this view after observing her friend's reports of suicidal ideation go unheeded by counsellors prior to the friend's suicide, as well as after an unhelpful experience with one of her own counsellors.

> If I wanted to bring up any suicidal feelings or anything like that, I kinda felt like I shouldn't have been bringing it up; I was kinda made to feel like it was wrong for me to be bringing this up even though it was my counselling session. [A.B.: What made you feel that way?] She [counsellor] didn't seem very interested. She was looking around and she wasn't really concentrating on me. … It was really just anything suicidal that I wanted to bring up; she kind of brushed it off. Kinda like it didn't matter what I felt. (Tina)

The counsellor's seeming disinterest in the topic made it difficult for Tina to be open about her suicidality. She also desired reassurance from the counsellor that suicidal ideation "wasn't wrong, that what I was feeling was okay." Therefore, while participants wanted an indirect approach in counselling to discussions of suicidality, they also wanted to feel that it was a welcome topic in sessions and not viewed as a sign of wrongdoing or mental illness. Haven also described how difficult it was to talk about suicidality and offered some advice to counsellors regarding this subject.

> I would weigh the advantages and disadvantages of bringing it [topic of suicidality] into the conversation and figured I could get really upset or I could not get upset, and just keep talking about what we're talking about but not solve anything. [A.B.: Did the counsellor know that you were having suicidal thoughts?] Sometimes if I was really down, she would ask me questions like, "Have you had any suicidal thoughts lately or are you leaning in that direction?". [But] I think she kind of assumed that I wasn't [having suicidal thoughts] if I was really happy when I saw her, and didn't ask. … Once we're talking about it, I still have a little bit of a hard time bringing it out into the open, but eventually I will with a little bit of pushing. It just takes a little while, and I don't think they [counsellors] have enough patience. (Haven)

Thus, while participants beseeched counsellors to "let [us] open up to you" and "go in the direction [we] want to" in regard to discussing the topic of suicidality, at the same time they admitted that such a laissez-faire approach may not have been optimal when they eventually did feel ready to talk about it, at which point they

preferred "a little bit of pushing." Suicidality seems to have been a difficult topic for participants to address, as it probably is for all adolescents, because they may have been bewildered by their suicidal thoughts and actions without having any context of understanding to place them in. They may have believed that the suicidality had hurt their families and felt guilty as a result; Haven alluded to this in her description of family therapy as "trying to guilt me into something by telling me that it really hurt my family." There was also an element of anxiety about being judged negatively or diagnosed as mentally ill due to suicidality, as manifest in Tina's plea for reassurance that it was "okay" to feel suicidal. Not surprisingly, participants wanted counsellors to reroute the topic of suicidality by talking about other subjects first, then introducing the topic of suicidality slowly. This strategy would have allowed trust to develop in the counsellor, so that further exploration of suicidality was then possible. However, participants also wanted counsellors to be ready and willing to discuss the topic of suicidality once the participants themselves brought up the subject.

Summary of Themes

Five main themes were identified in participants' stories of their counselling experiences. First, participants appreciated openness conveyed by counsellors through attentiveness, respect for adolescents' views, privacy, and autonomy, and genuineness without self-disclosure. It seems that expression of these qualities communicated to participants a sense of counsellors' caring and concern. As a result, counselling experiences perceived as helpful were generally characterized by counsellor openness; conversely, negative counselling experiences were often defined by its absence.

Secondly, participants expressed a need for direction in counselling sessions. Such direction involved clear delineation of goals, which may have helped to educate participants about the process of counselling and instituted a sense of structure. The need for direction also involved a need for guidance of session topics by counsellors, including the use of open yet focused and detailed questions. Participants perceived some positive counselling experiences to be characterized by the presence of such direction in sessions, whereas its absence marked some negative experiences.

Third, participants felt unattended to in some of their counselling encounters in terms of their unique needs and desires. This theme is comprised of two elements: feeling pigeonholed in counselling due to a perceived lack of flexibility in its methods and feeling disregarded in counselling because of seemingly inappropriate approaches based on the participants' age or developmental level. These factors led to a sense of diminished responsiveness to participants' individual needs; participants found such unresponsiveness in counselling interventions to be frustrating and unhelpful.

Fourth, participants yearned for a relational climate in counselling. They wanted to interact with counsellors who were close to them in age, which seemed to signify attunement to the adolescent culture and thus facilitated the therapeutic bond. Participants also desired a comforting physical setting in counselling, as they felt more inclined to talk openly in such an environment. Counselling experiences that participants perceived as unhelpful were often characterized by counsellors who seemed too "old" to understand them or by unwelcoming physical surroundings.

Finally, participants expressed a wish for counsellors to address the topic of suicidality in a gentle, indirect, and patient manner. This had not always occurred in

their counselling experiences, and there was a sense of anxiety and ambivalence in their comments regarding discussing suicidality with counsellors: thus, they wished that counsellors would "re-route" the topic. Participants also felt that when they were finally ready to discuss suicidality, they wanted the counsellor to address it directly, rather than to avoid or ignore it.

Paradigm Cases

Following completion of the thematic analysis, a second method of interpretation was carried out. The strategy of paradigm cases (Benner, 1985; 1994; Benner et al., 1996), which allows the contextualization and amplification of findings, was used to analyze two participant narratives that stood out and demanded further attention. As Hein and Austin (2001) indicate using the analogy of a prism, these instances were examined from a different angle. Being both a recognitional and a presentation strategy, paradigm cases provide vivid descriptions of a phenomenon (Hinck, 2004). By revealing latent meaning in the narrative data, they comprise another strategy for researchers and readers to gain a better understanding of the phenomenon under study. In the following sections, I present two contrasting paradigm cases – spotlighting the experiences of Haven and Matt – to illuminate some subtle yet significant elements in these participants' experiences of counselling.

The selection of Haven and Matt's experiences as paradigm cases was based on my finding that while immersed in the narrative data, I was particularly struck by these participants' stories, due to both their individual impact on me and the marked difference between them in terms of the polarity of counselling experiences. For the latter reason, the two paradigm cases below are presented as contrasting entities.

Haven's Case

Several of Haven's counselling experiences (and in particular, the one with the counsellor "Susan") were described as so distinctly negative that her story stood apart from the others. While each of the participants reported at least one negative counselling encounter, such experiences seemed to define Haven's story. I wanted to further explore the negativity of her counselling experiences, which had rendered her story so remarkable.

I read Haven's story again, this time focusing on the underlying meaning, rather than on the overt spoken messages. Upon reflection, two features of Haven's counselling experiences emerged as particularly salient: feeling expendable due to a lack of continuity in counselling providers and feeling mute due to a lack of a heard voice within counselling. These aspects played a key role in Haven's dissatisfaction with the counselling process. Additionally, they may have engendered in Haven a sense of disempowerment. These ideas are presented in detail below.

Feeling expendable due to lack of continuity.

While she did not explicitly comment on this in her interview, Haven experienced a considerable lack of continuity in her counselling providers. Her statement, "I've seen so many therapists," is illuminating. She met with at least four different counsellors while in junior high school, during which time she was acutely suicidal. According to Haven, the frequent changes in counsellors were due to their "leaving" or "having to cancel a lot of [their] patients" for personal reasons, not for reasons related to Haven's counselling needs. It is not surprising that with almost no continuity in counselling providers, she had difficulty recalling some of their names.

Furthermore, perhaps not wanting to threaten whatever little safety and security she perceived (or wished) there to exist in the relationships with her counsellors, Haven was reluctant to disclose her suicidality to them for fear of "ruin[ing] the good mood in the room." Her comment reflects the superficiality of these counselling relationships, as the social atmosphere seemingly took precedence over genuine interaction, at least from Haven's perspective. This superficiality may be another manifestation of the short-term nature of her counselling encounters. Thus, the lack of continuity in providers seems to have made it difficult, if not impossible, for Haven to develop trust in her counsellors. Since at least some degree of trust is an essential element of counselling, this lack of continuity undoubtedly diminished the capacity of the counselling process to effect meaningful change for Haven.

As do some other researchers who use hermeneutic phenomenology (e.g., Hein & Austin, 2001), I explored the narrative data for words or phrases that were evocative of images symbolic of the participant's broader experience. I found that one of Haven's statements, "I was one of the ones that got cancelled," resonated strongly each time I read her story. This phrase is meaningful in several ways: to feel that one was "cancelled" connotes acts of dismissal, termination, or even abandonment, which would likely bring forth emotions of sadness, anger, shame, and the like.

Moreover, Haven's phrase evokes a powerful sense of actually being chosen to be cancelled, perhaps due to being in some way deserving of the cancellation. If understood in its most dramatic sense – and a young teenager such as Haven would likely perceive it in such a way due to adolescent egocentrism – the above phrase connotes a feeling of being unimportant and not worthy of the counsellor's care;

ultimately, feeling expendable. This underlying meaning in Haven's story may help to explain her dissatisfaction with counselling, which was of such magnitude that she felt compelled to compile a list of "the things [she] hated about therapists."

Reading Haven's story, I imagined a canoe set adrift on a turbulent river, being bounced around by the current and at times touching the river bank; however, never able to dock for any significant length of time as it continues to be pushed along aimlessly, endlessly. Likely due to the lack of continuity in contact with counsellors, Haven seemed to not have developed much rapport with any of them. Just like the canoe – helpless to stop the unpredictable current – she simply went along with each next encounter and never engaged fully with any of the counsellors, probably having learned that to do so is futile, given the lack of continuity in services. She had no impact on the counselling process and was at the mercy of the counsellors or the counselling agencies; this may have led her to conclude that she did not matter.

Reflecting on the topic of discussing suicidality in sessions, Haven criticized counsellors for not demonstrating adequate patience in this regard. However, it is plausible that having never "docked" with any one counsellor for very long, there simply was not enough time for trust to develop sufficiently to allow the exploration of sensitive topics like suicidality. Such lack of continuity in counselling services is also evident in the narratives of Alicia and Tina, who reacted to it negatively. These participants yearned to engage in counselling, but never realized the opportunity to do so if, due to the short-term nature of counselling encounters, adequate trust toward the counsellor was not established. This in turn would inevitably diminish the efficacy and value of the counselling process, as it seemed to do for Haven.

Feeling mute due to lack of a heard voice.

Haven's story contains another aspect that exists "between the lines" and may further explain the strong impact of her story. On at least three different occasions, Haven experienced a sense of not being heard in counselling: first, when she felt unwelcome to share her opinions in the "parent oriented" family therapy; second, when she vocalized her dissatisfaction regarding counselling but apparently no changes were made; and third, when she arrived at the conclusion that counsellors took her inner experiences for granted ("they assumed that because I didn't show signs of depression, that I didn't have it"). Although she attempted to communicate openly in counselling, Haven did not feel that her voice was actually heard; in effect, she felt mute.

The lack of counsellor genuineness that Haven experienced in some of her counselling experiences may have contributed to this feeling of muteness. Haven's comment, "it was really hard for me to be angry with [the counsellor] … to be mean to someone who just smiles at you" is telling. It reflects her difficulty with addressing important issues in counselling because of feeling unable or unwelcome to articulate her concerns. This difficulty likely contributed to Haven's dissatisfaction with Susan (one of her counsellors who "always ha[d] a smile planted on their face whether or not they really mean it") from whom she felt quite disconnected. Overall, feeling mute due to not having a heard voice seemed to define most of Haven's counselling experiences, and, combined with the lack of counsellor genuineness she experienced, likely contributed to further dissatisfaction with the process of counselling in general.

Taking the imagery introduced in the previous section a step further to incorporate this sense of muteness, I now picture Haven sitting in the canoe being batted around by the current, but she has no paddle – therefore, she is powerless to change her course. She is pleading for help, even yelling for it at times, but help is not forthcoming. (Indeed, Haven stated that even though she had asked for help, "nobody ever changed anything.") All she can do is resign herself helplessly to the situation – and in fact, she does come across in her narrative as rather jaded by counselling. Without having a say in the direction of the symbolic canoe, Haven was not able to benefit much from counselling and thus found it to be a generally negative experience.

Had Haven been given the opportunity to have a voice and to feel heard in counselling, she may have been able to use this tool – like a paddle – to steer the counselling process in a direction that she found beneficial, in contrast to what she experienced. It is possible that her lack of a heard voice in counselling may have had an effect on how she viewed her ability to change not only aspects of the counselling process, but also aspects of her life outside of counselling. In other words, she may have felt less able to improve difficult areas of her life based on her felt lack of ability to influence her counselling encounters. This in turn may have reinforced any prior negative beliefs about herself that she may have held; if the latter did indeed occur, Haven may have continued to possess low self-esteem and to engage in destructive behaviours. Ultimately, this implies that her lack of a heard voice in counselling may have impeded her process of recovery from suicidality, presumably the opposite of the counselling's intended outcome.

Feeling insignificant due to disempowerment.

These two aspects of Haven's counselling experiences – the lack of continuity in providers and the lack of a heard voice – appear to add up to an overall impression of disempowerment. Individuals who are disempowered have little authority and control and their opinions do not matter, thus, they feel trivialized and insignificant; elements of disempowerment can be seen in Haven's counselling encounters. In fact, viewed in this light, it can be seen that each participant in this study had at least one disempowering counselling experience, in which they felt constrained or unimportant. For instance, Tina felt that her concern about her memory loss was disregarded by her counsellor; Simone seemed to have no opportunity to talk in family therapy sessions; Alicia got reprimanded for calling her counsellor a "shrink" but the meaning of her sentiment was not explored; and Matt experienced a lack of attention to his individual needs. Such experiences were perceived as negative by participants because they thwarted the expression of thoughts and feelings, denigrated subjective sense of worth, and thus were ultimately disempowering.

The disempowerment of adolescents in counselling can perhaps be seen as analogous to the treatment of this age group by North American society, in which adolescents are generally viewed as children in adults' bodies, prone to mood swings and flightiness, and not sufficiently mature for most adult tasks (for instance, voting and driving). As a group, they are treated as irresponsible and unreliable, and may be viewed with mistrust. Thus, participants potentially already felt disempowered and discredited within society at large; if their counselling experiences also resulted in a sense of disempowerment, their feeling of insignificance may have been reinforced.

Based on the participants' stories, a sense of insignificance engendered in counselling may have led them to disengage from the process of counselling. Such disengagement was manifested by actions that helped the participant to withstand the counselling or to hasten its termination, versus intentionally ending the counselling. Thus, participants said certain things to please counsellors in order to avoid further counselling or passively went along with the counselling process, sometimes in order to gain some other benefit. For example, Haven stated regarding counselling that she saw as unhelpful that she "stayed with it [and] didn't really say anything because it was better than sitting in school for an afternoon;" likewise, Matt admitted that he continued seeing his school counsellor despite lack of benefit because this allowed him "time off class." Simone revealed that, in order to pacify counsellors, "a lot of times I would just give the answers I knew they wanted; they were like, 'Have you had any suicidal thoughts?' and I'd be like 'No, no' even if I had." This had occurred when she felt disengaged from the counselling and did not wish to continue attending, but was not able to express this idea to the counsellor. Simone further recalled that she wished to please her counsellor by leading the counsellor to think that "she'd done a good job and I wasn't [suicidal] anymore, even if I was." Similarly, Tina reported that at times, she was simply "agreeing with everything" the counsellor said in order to get out of counselling she viewed as unhelpful. These passive expressions of disengagement from the counselling process likely reflect the participants' felt inability to openly express their dissatisfaction, possibly owing to a sense of disempowerment engendered in counselling experiences.

Matt's Case

Matt's last counselling experience was diametrically opposed to Haven's counselling experiences due to its perceived helpfulness; in fact, it was arguably the most positive counselling encounter in all of the participants' stories. For this reason alone, it stands out. In addition, the factors that made Matt's experience "the greatest thing since sliced bread" were greatly compelling to me and, as with Haven's case, I wanted to uncover them and explore the meaning behind them.

After studying Haven's paradigm case, Matt's story naturally emerged as a contrast case, because upon analysis, it is so clearly one of empowerment. It reflects Matt's sense of being empowered to influence the course of his counselling and his life. The counsellor's comments, as remembered by Matt, "You can do this on your own" and "You have a brain, and you can use it, and I know you will," are just two examples of the process of empowerment. Furthermore, the counsellor encouraged Matt to psychologically shift away from his parents and their sphere of influence over his life. Matt appreciated this empowering approach, and he reveled in feeling that the counsellor believed in his abilities to overcome problems. It was a feeling that he had not experienced before and it propelled him toward therapeutic change.

Another likely reason for Matt's positive perception of this counselling experience is the sense that trust and safety were nurtured within the counselling relationship. For instance, the counsellor met with Matt's mother but did not divulge any personal information about him to her. Additionally, Matt was permitted and even welcomed by the counsellor to voice his opinions in counselling (for instance, his views regarding the above meeting), which led him to feel heard and respected.

Matt also found that his counsellor was able to make him "realize the truth [he had] inside" by drawing out underutilized elements of his personality and encouraging him to strengthen those elements. These factors were further experienced as empowering by Matt, contributing to his satisfaction with this counselling encounter.

If Matt's case is analyzed in view of the themes and subthemes identified earlier, it is clear that his counselling encounter fits into most of the groupings that address counselling experiences generally identified as helpful by participants. He perceived a high level of attentiveness, respectfulness, and genuineness without self-disclosure on the counsellor's part. He experienced direction in counselling sessions, especially in regard to the counselling goals. He also felt very comfortable with the counsellor and was able to discuss his suicidality at the pace that he desired. He did not perceive the interventions used in counselling as age-inappropriate or inflexible, other than feeling constrained by the time limits of the therapy hour. All of these factors seem to have been empowering elements in Matt's counselling experience.

The symbolic metaphor presented earlier in this chapter utilized the image of an adolescent stranded in a canoe, attempting to navigate the rough waters, but not able to dock the canoe, to steer it, or to obtain help. This image relates to the feeling of expendability and of muteness in counselling that was identified in Haven's story. The metaphor may also fit the participants' overall experience of adolescence itself, in the sense of a river that is calm in places but has many precarious undercurrents (i.e., life problems) and is interspersed with dangerous rapids (i.e., suicidality). The participants generally needed help – a symbolic paddle – to navigate the rough parts of adolescence, as they would in a canoe stranded in rough waters.

In the context of Matt's extremely positive counselling experience, the canoe imagery shifts; now the adolescent and the counsellor both sit in the canoe and steer it together through the rough waters. It may take some time to reach their destination, but the adolescent is confident – as was Matt – that this is possible, owing to a sense of empowerment gained in counselling. This empowerment seemed to be beneficial in Matt's experience and contributed to his satisfaction with the counselling process.

Summary of Paradigm Cases

I chose Haven's overall experience in counselling as a paradigm case because it was so overwhelmingly negative. Her story is characterized by a lack of continuity in counselling leading to a sense of expendability, and a lack of feeling heard leading to a sense of muteness. These shortcomings impacted the development of trust in her counselling relationships. Not having the opportunity to build trust and thus to feel comfortable expressing her thoughts and feelings in sessions may have meant that Haven was prevented from benefiting fully from the counselling process. I believe these factors added up to a profound sense of disempowerment for Haven; as a result, her ability to effect change, both in counselling and in her life, was likely diminished. This raises the disturbing possibility that her counselling experiences may have ended up augmenting, rather than decreasing, her suicidality. The challenge that this poses to counsellors working with suicidal adolescents is discussed in the next chapter.

On the other hand, Matt viewed his most recent counselling experience as exceedingly positive and it was thus chosen as a contrasting paradigm case. Matt did not feel expendable or mute in this experience, and in fact, a process of empowerment within the counselling seemed to be very beneficial in helping him to overcome his

problems. Matt's counsellor helped him to navigate through the life difficulties Matt encountered, including suicidality, as a wilderness guide would do for someone in a stranded canoe. Thus, Matt's experience also showcased the important role of the relationship between counsellor and client in bringing about therapeutic change.

Synthesis of Themes and Paradigm Cases

The thematic analysis uncovered five themes in the participants' narratives. Some of the themes and their associated subthemes were related to the participants' positive counselling experiences, while some of the others reflected their negative experiences. In general, the findings show that the participants liked a structured yet flexible counselling approach and counsellors who were able to convey caring and to take the participants' needs into consideration. The counselling that participants saw as beneficial helped them to steer their lives in a more favourable direction; therefore, the canoe metaphor applies in the context of the thematic analysis findings as well, in that the identified themes point to useful counselling strategies that acted as symbolic paddles for participants stranded in the rough currents of adolescence.

The two paradigm cases presented in this chapter demonstrate the role that counselling played in either empowering or disempowering participants. The factors that I have identified as central to this dynamic – continuity in counselling providers and having a heard voice in counselling, or else their absence – were strongly linked to the relationship between the participant and the counsellor. Indeed, several of the identified subthemes can be viewed as important components of a strong therapeutic relationship. The relation of the thematic findings to the therapeutic relationship is discussed in the following chapter.

In summary, based on the contrasting cases of two participants, a positive outcome in counselling seemed to be correlated with a dynamic of empowerment; conversely, a negative outcome seemed tied to an overall sense of disempowerment. Participants may have been vulnerable to the latter dynamic based on society's rather negative view of their age group, which itself can be disempowering. Reiteration of this negative view in counselling may have reinforced the participants' destructive beliefs and behavioural patterns. It is as though, while sitting in the canoe and battling the current, the adolescent were to discover that the people watching events unfold from shore, instead of providing support and help, can offer only discouraging or trivializing messages. Such disempowerment in counselling may thus have had a negative effect on the participants and potentially intensified their suicidal impulses. On the other hand, if a sense of empowerment was proffered in counselling, then the participants seemed eager to use it to overcome their problems, including suicidality.

Seeking Empowerment Through Connection

The synthesis of themes and paradigm cases has thus far identified a sense of disempowerment in the participants' counselling experiences as a crucial element in their negative perception of counselling. On the other hand, participants reported the experiences in which they felt connected to the counsellor to be particularly helpful; the role of the therapeutic relationship was clearly an important one. Taken together, these two notions suggest that during counselling following suicidal experiences in their adolescence, the participants were seeking empowerment through connection. Some of them found it, others did not; but they all seemed to be searching for it. This idea is a thread that weaves together the findings and is discussed in the next chapter.

CHAPTER 6: DISCUSSION

In this chapter, I examine the findings in the study from several viewpoints: integration of the findings with the research literature, further scrutiny of the findings, and discussion of the considerations in this study. Next, I identify the new knowledge resulting from this study. The implications of the findings for counselling practice, service administration, and future research are then elucidated. I conclude with a reflection on my own process of engaging in this study.

Integration of the Research Findings With the Literature

This section addresses the correspondence of the findings of this study to relevant reports in the literature. Specifically, the presence of suicidality risk factors in participants' stories, the insight gained from the identified themes and paradigm cases, and the role of the therapeutic relationship in participants' experiences are discussed in relation to existing research.

Suicidality Risk Factors Evident in Participants' Narratives

Although risk factors in adolescent suicidality were not the focus of this research, it is interesting to note their presence in the participants' narratives. For example, depression, which has been strongly linked to suicidality (Joseph et al., 2003; Roberts et al., 1998) seemed to be a risk factor for Haven, who reported having been diagnosed with it, and for Simone, who had been prescribed antidepressant medication. A history of suicidality, another significant risk factor (Roberts et al., 1998), was evident in the stories of Alicia, Simone, Haven, and Matt, as each had experienced suicidal ideation or behaviours on more than one occasion. Risk factors

related to family functioning (Gould et al., 1998; Morano et al., 1993) may have been relevant for Haven, Tina, and Alicia, whose parents had divorced; additionally, Tina's aunt had been murdered, Alicia's brother was diagnosed with schizophrenia and had attempted suicide, and Matt lived apart from his parents for several years. Finally, ostracism related to sexual orientation, another risk factor (Russel & Joiner, 2001), may have played a role in Matt's suicidality; he self-identified as gay and reported that this was not accepted by his parents.

Relation of Themes to the Literature

Because the importance of suicidal persons' subjective perspectives has only very recently been recognized by researchers (e.g., Cutcliffe, 2003), and in particular, their perspectives on counselling experiences in adulthood (Hoover & Paulson, 1999; Paulson & Worth, 2002) and in adolescence (Everall et al., 2006; Everall & Paulson, 2001; Paulson & Everall, 2003), the amount of direct comparison that can be made between the current study and the existing literature is limited. Furthermore, previous research has explored the counselling experiences of suicidal adolescents mostly in the context of the helpfulness of such experiences, thus possibly leaving other aspects of the experiences unaddressed. Therefore, most of the findings of the present study have only an indirect relation to the literature, and these links are discussed below. Some generalizations have to be made to make comparison possible; for instance, the five themes identified in participants' narratives can be holistically seen as relating to the importance of the therapeutic relationship, and thus are discussed in that context. This correspondence is addressed in a later section.

In comparing the individual themes identified in this study to the existing literature, some parallels can be observed. The first theme, Appreciating Counsellor Openness, which reflects the value of counsellor attentiveness, respectfulness, and genuineness as perceived by participants, appears related to the importance of the therapeutic bond between the counsellor and the client, one of the components of the therapeutic alliance as described in Bordin's (1979) model. This idea is similar to the findings of Everall and Paulson (2002) who found that adolescent clients experienced as helpful those counsellors that were open, authentic, caring, and respectful; thus, the authors concluded that counsellor qualities play an important role in counselling work with teenagers. Secondly, in a study of suicidal adolescents' perceptions of helpful aspects of counselling, Paulson and Everall (2003) found that the adolescents very consistently identified as helpful their experiences of feeling respected, understood, and accepted in the therapeutic encounter, which again corresponds somewhat to the first theme in the current study.

The second theme, Needing Direction, is comprised of subthemes addressing participants' need for goal delineation and guidance of session topics, and thus is also related to Bordin's (1979) model which emphasizes agreement between the client and the counsellor on the tasks and goals in counselling. This theme similarly corresponds to the findings of Paulson and Everall (2003), which showed that suicidal adolescents viewed as helpful those counselling interventions that had a sense of direction toward a goal. Based on further research with suicidal teenagers, Everall et al. (2006) suggest that counselling work with this population should incorporate manageable goals and purposeful action.

It was suggested earlier that one reason for the identified importance of direction in participants' counselling sessions may be the valuable role of such direction in educating clients about counselling; Everall and Paulson (2002) assert that client education about the process of counselling is essential in working with adolescents, who may have unclear or inaccurate expectations about counselling. Furthermore, Jobes et al. (2005) suggest that an active and directive role may be particularly indicated in counselling work with suicidal adolescents, as such clients are likely to feel out of control, and to therefore require direction from counsellors. While this advice was geared toward crisis intervention work rather than ongoing counselling, there is no reason to believe that it would not be applicable in the latter setting.

The third theme, Feeling Unattended to as an Individual, which is based on participants' perception of being pigeonholed and disregarded in some counselling encounters, has only an indirect relation to the literature. Everall and Paulson (2002) found that adolescents respond better to counsellors who are flexible in adjusting therapeutic interventions to suit clients' variability. Based on research with adults, Henkelman and Paulson (2006) suggest that counsellors should cultivate flexibility and responsiveness, implying that counsellors need to strive to understand each client's unique characteristics and needs. Leenaars (2006) similarly proposes that counsellors working with suicidal persons should know the client as well as possible, and then cater counselling interventions to the client's needs, as "(t)here is no one implication for psychotherapy. *The* manual, *the* cookbook does not exist" (p. 318). While these researchers examined the presence of responsiveness in counselling,

rather than its absence as found in the present study, Paulson et al. (2001) hypothesize that many negative experiences in counselling may indeed be influenced by a lack of responsiveness.

Interestingly, the third theme (Feeling Unattended to as an Individual), which addresses responsiveness in counselling approaches, may be linked closely to the first theme addressing valued counsellor qualities. Everall and Paulson (2002) report that an adolescent's positive view of a counsellor encourages the adolescent's perception of counselling tasks as appropriate. In other words, a participant's perception of the counsellor as helpful may have increased the likelihood that methods used by that counsellor were also seen as beneficial, which may be similar to Asch's (1946) concept of the halo effect. This implies that a positive perception of counsellor qualities may be fundamental to having a good counselling experience, as such a perception may cast a more favourable light on other aspects of the encounter.

The fourth theme, Yearning for a Relational Climate, reflecting participants' desire for a counsellor attuned to adolescent culture and a suitable counselling setting, as well as the last theme, Wishing that Counsellors Would "Reroute" the Topic of Suicidality, have only a very limited connection to the existing literature. In Everall and Paulson's (2002) research, a teenage participant characterized counsellors who are significantly older than their adolescent clients as condescending; this view may help to explain the preference of participants in the current study for counsellors close in age to their own. Finally, Paulson and Everall (2003) found that a major theme in suicidal adolescents' perceptions of helpful aspects in counselling centered on communication of topics related to suicidality.

The Role of the Therapeutic Relationship

Because the five themes taken together address counsellors' qualities and behaviours that were manifest in the interpersonal context, the themes can be viewed as relating to the concept of the therapeutic relationship between the counsellor and the client. Overall, the findings connote a sense of partnership between clients and counsellors that highlights the core conditions of therapy identified by Carl Rogers (1957) in the client-centered approach to counselling. The next section more closely explores the role of the therapeutic relationship in the findings of this study and the fit between these findings and the client-centered counselling approach.

It is widely recognized that the therapeutic relationship is vital in any counselling endeavour (Lambert, Bergin, & Garfield, 2004), and that with suicidal clients in particular, the relationship is a prerequisite for successful therapy (Collins and Cutcliffe, 2003) as well as a critical predictor of outcome (Leenaars, 2006). The American Psychiatric Association (2003) recommends that in the care of suicidal individuals, the first step following assessment should be the establishment and maintenance of a therapeutic alliance. Thus, the findings in this study reflecting the significance of the therapeutic relationship certainly dovetail reports on this subject in the literature.

Right from the time of the participants' interviews, I was very aware of the importance of the therapeutic relationship in their counselling experiences. Many of their accounts were specifically focused on this relationship or, in a related vein, on particular interpersonal events in counselling. Predictably, participants' perceptions of the therapeutic relationship seemed to be highly linked to their overall appraisals of

the counselling experiences. The significance of the therapeutic relationship is also evident in the thematic analysis results, particularly in the first theme which focuses on counsellor openness and thus represents interpersonal factors in the counselling encounter, and, to a lesser degree, in the themes addressing the relational climate in counselling and responsiveness to the client's individual needs.

Based on this study's findings, the therapeutic relationship played a key role in the participants' experiences of counselling, reiterating the common premise of most theories of adolescent psychotherapy (DiGiuseppe et al., 1996) as well as the conclusions of various studies with adolescent clients (e.g., Everall & Paulson, 2002), namely, that the relationship is central to the outcome of counselling. Furthermore, based on the specific details of the first theme in this study (Appreciating Counsellor Openness), it can be argued that the type of therapeutic relationship that participants valued was grounded in the client-centered approach to counselling; in this approach, as described by Raskin and Rogers (1995), certain core counsellor attitudes constitute important conditions of therapeutic effectiveness. Indeed, the counsellor qualities that were identified in participants' narratives as valuable, namely, attentiveness, respect, and genuineness, are somewhat parallel to the three facilitative conditions of client-centered therapy: empathy, unconditional positive regard, and congruence.

However, the analogy between the client-centered model and the kind of counselling that participants in this study appreciated may be applicable only to the interpersonal qualities of counsellors and may not extend to a broader approach to working with suicidal adolescents. The second theme identified in the findings indicates that participants felt a need for direction in counselling. This does not fit

with the largely nondirective stance of client-centered counselling, in which the client is encouraged to determine such direction (Raskin & Rogers, 1995). Support for the importance of direction in counselling work with suicidal adolescents is provided by Barbe, Bridge, Birmaher, Kolko, and Brent (2004) who discovered that structured therapeutic approaches yielded better outcomes with this client population than did nondirective supportive therapy; therefore, also throwing into question the role of a client-centered counselling approach to working with suicidal adolescents.

Furthermore, the nondirective nature of client-centered therapy may disallow the counsellor from confronting the client on issues that the client may wish or need to have challenged. This is illustrated by Haven's curious comment that "some of my issues were anger issues, and it was really hard for me to be angry with [nondirective counsellor]... It's hard to be mean to someone who just smiles at you or says, 'That's okay, I understand'." It seems that Haven wanted to be confronted about problems, rather than to be validated or placated, in order to facilitate expression of her anger; however, this kind of confrontation is not typically done in nondirective counselling. Interestingly, Haven's sentiment is nearly identical to Raskin's (1978) reflections on his experience as a client-centered therapist: "It was difficult for [clients], because I was so nice, to tell me things that were not nice … it was hard for [them] to get angry at me" (p. 367). Therefore, while client-centered therapy may seem to be a good fit for suicidal adolescents in terms of the counsellor characteristics being facilitative of therapeutic change, its nondirective nature may hinder resolution of the adolescents' problems.

Participants' preference for direction in counselling is not a particularly surprising finding. Having a sense of direction in counselling sessions may be important to suicidal adolescent clients for several reasons: probably most teenagers, being not yet fully mature or independent, still need some adult guidance, including that of counsellors; secondly, adolescents usually know little or nothing about the process of counselling and its expected outcomes, and thus need direction as a form of education in that regard; thirdly, because suicidality is correlated with depression which is likely to sap the sufferer's motivation (American Psychiatric Association, 2000), suicidal teenagers may need counsellors to take a more active role in sessions specifically in order to offset their lack of motivation. Based on their unique needs, suicidal adolescents may thus be particularly likely to appreciate and benefit from a sense of direction in counselling.

However, the literature on adolescent psychotherapy does not generally advocate counsellor directiveness. For instance, Church (1994) found that teenage clients fared better with a less directive approach, defined by counsellors offering support rather than advice. Likewise, Everall and Paulson (2002) and Paulson and Everall (2003) found that teenage clients, many of whom were suicidal, responded positively to a nondirective counselling approach. The explanation offered by the researchers for the above findings is that adolescents generally do not want their developing sense of autonomy challenged or limited by directive counsellors who, based on behavioural aspects, may be seen by teenagers as authority figures rather than allies in the therapeutic encounter.

In an attempt to reconcile these contradictory findings regarding the role of the counsellor in directing interactions between counsellors and clients, it is important to examine what is meant by the term "direction" in counselling. In general, researchers (e.g., Church, 1994) who advocate a nondirective approach to counselling work with suicidal adolescents portray the alternative – directiveness – as a process of advice-giving and imposing an agenda on the counselling encounter. However, the need for direction in counselling identified in the current study is based on participants' stated preference not for counsellors who engage in the above practices, but rather, who set clear, manageable goals and who actively facilitate the flow of session topics.

Based on this discrepancy in meanings, the term used in this document, "direction," does not equal the concept of "directiveness" as it is conceptualized in the literature. The idea of direction signifies the counsellor's practice of setting goals in counselling and facilitating the process of the sessions, while the traditional notion of counsellor directiveness refers to the practice of advice-giving and attempting to control the outcomes of counselling. The former seems much less likely than the latter to limit adolescents' sense of autonomy and thus may be more acceptable to teenage clients. The nuances of these variations in counsellors' behavioural styles require further scrutiny, which follows below.

Developmental tasks mirrored in the therapeutic relationship.

A main developmental task of adolescence is separation and individuation from the family; in this process, teenagers detach psychologically from their parents (or other attachment figures) and develop an independent identity, which has been referred to as a discovery of one's own voice (Doctors, 2000). This developmental

task is seen as dependent on continued attachment to a responsive caregiver, thus, teenagers experience simultaneous needs for attachment and separation-individuation. Difficulties in achieving separation-individuation may lead to negative outcomes for the adolescent, one of which may be suicidality (Daniels, 1990). Given that clients naturally bring their developmental needs with them into the counselling milieu – and that the weakening in recent times of the institution of the family has contributed to potential problems in achieving the developmental tasks of adolescence, because this achievement is dependent on a sense of connectedness (Portes, Sandhu, & Longwell-Grice, 2002) – suicidal adolescents may experience particularly pressing, concurrent needs of attachment and separation-individuation within their counselling encounters, just as they are likely to do within their families.

My findings, which highlight the value of interpersonal factors and direction, imply that the counselling process with adolescents may be somewhat analogous to a parent-child relationship, because parents have to provide guidance to their offspring in the context of an engaged relationship. More specifically, the preferred counselling stance with suicidal adolescents, based on participants' stated needs and desires, may be somewhat akin to an authoritative parenting style (Baumrind, 1991), characterized by responsiveness to needs combined with a directive approach to guiding behaviour. In literature reports addressing adolescents' resilience to adverse situations, parenting styles that combines structure and direction with warmth and nurturance have been identified as valuable (Rak, 2002; Smokowski, Reynolds, & Bezruczko, 1999), and in Crook's (2003) study of suicidal teenagers, the importance of family was emphasized; participants reported that parents mattered to them "more than anyone else" (p. 33).

It is noteworthy that most of the participants in the current study experienced disrupted family functioning due to parental divorce, psychiatric illness in a sibling, or living apart from parents, which may have negatively impacted the parents' ability to fulfill their parenting role. This study did not aim to address parental functioning or its putative role in the development – or the resolution – of suicidality in adolescence. Nevertheless, it is plausible that participants may have desired counsellors to take on a relatively parental role to compensate for any deficits in that regard in their families. This idea corresponds to the assertion of Portes et al. (2002) that family problems that lead to loss of connectedness may indirectly contribute to suicidality in adolescence; thus, a sense of connection or attachment within the counselling relationship that is somewhat akin to a parent-child relationship may be desirable to suicidal adolescents.

Despite this speculation, participants in this study preferred counsellors who were close to their age, rather than significantly older, as a parent would be; I framed this as a desire for counsellors who are attuned to the adolescent culture. Therefore, factors related to this – such as teenagers' perception of young counsellors as better able to empathize with them – may have been a competing, and overriding, force in the participants' preferences. This need for connection on a peer level, rather than on a parent-child level, likely corresponds to the aforementioned developmental task of separation-individuation. As I have identified previously, participants benefited from empowering experiences in counselling, which cannot occur if the client is treated like a child; rather, empowerment occurs in the context of being treated as an equal. Participants may also have been unwilling to have a symbolic child role with older, "parental" counsellors due to the adolescent drive for autonomy.

Taken together, the participants' identified desire to interact with counsellors on both a parent-child level and a peer level, based on developmental needs, relates to the thematic thread identified earlier in the participants' narratives: the participants' search for empowerment through connection. They sought this goal in order to both experience a sense of attachment in counselling and to facilitate the developmental task of separation-individuation via feeling empowered by counsellors to, in Matt's words, "realize the truth they have inside."

Relation of Paradigm Cases to the Literature

Haven's paradigm case illuminated two core characteristics of her experiences in counselling: feeling expendable due to lack of continuity and feeling mute due to lack of a heard voice. Neither issue has received much attention in the literature. In regard to the issue of continuity, Hulten and Wasserman (1998) report that suicidal individuals who had contacts with multiple caregivers over time had a much higher rate of suicide than expected, possibly because they never experienced attachment to any of the caregivers. In terms of the second issue, lack of a heard voice, Everall and Paulson (2002) note that a sense of being heard in counselling may be particularly important to adolescents because of the critical role of self-expression in identity formation and autonomy development in this age group. However, neither of the phenomenological aspects (i.e., feeling expendable and feeling mute) has been studied previously in the context of suicidality in adolescence.

The previous chapter described how lack of continuity and lack of a heard voice may have contributed to a sense of disempowerment and insignificance for Haven. It was suggested that such processes may contribute to further suicidality in

vulnerable individuals. While this appears to be a neglected area in the literature, some studies have addressed the opposite process (i.e., empowerment) within the context of counselling. For instance, Everall and Paulson (2002) explain that a sense of empowerment in counselling allows adolescent clients to trust their ability to make decisions; Everall et al. (2006), based on research with suicidal teenagers, recommend that counsellors help clients to use and strengthen their social resources, which is akin to empowering the clients. Johnson (2003) notes that a new movement is afoot in the psychotherapy field to incorporate strength-based approaches into counselling work with adolescents, and she describes a case study from clinical practice of using such an approach to empower a client. Therefore, while this topic requires further study, empowerment-focused counselling approaches may be an important way of working with suicidal adolescent clients; they certainly present as a fitting antidote to the sense of disempowerment alluded to by one of the participants in the present study.

At this point, the thread of Seeking Empowerment Through Connection is again highlighted as an important element of participants' counselling experiences following suicidality. While having a therapeutic bond with a counsellor, participants appeared to be seeking to become stronger as individuals in control of their own lives. This has parallels to the developmental task of separation-individuation in the context of maintaining connection to an attachment figure. Empowerment in the counselling context may thus facilitate the resolution of suicidality, as it seems to have done for Matt, who experienced counselling as very empowering. Integrating the literature on adolescent development into the study of adolescent suicidality may result in a more comprehensive understanding of the processes involved in overcoming suicidality.

Further Discussion of the Findings

This section contains broader commentary on the findings along with my conjectures about their importance in light of the research literature. First, I discuss the lack of overt focus in the findings on suicidality. Next, I address the observation that participants' described counselling experiences are quite polarized in terms of perceived helpfulness. Finally, the notion of disempowerment within participants' counselling experiences is further addressed.

Lack of Overt Focus on Suicidality

When examining the themes and subthemes identified in the previous chapter, a curious detail becomes apparent. Only one theme is focused overtly on suicidality: namely, the theme labeled Wishing that Counsellors Would "Reroute" the Topic of Suicidality. No other theme relates directly to the subject of suicide and in fact, the other themes seem somewhat generic; if viewed out of the context of the research question, they could potentially apply to most counselling endeavours.

Benner et al. (1996) assert that interpretive research requires that silences in the findings, or expected stories that did not materialize, be attended to. As I expected more explicit emphasis on suicidality in the findings, the nonspecific nature of most of the themes was somewhat surprising. Because participants did not focus much on suicidality while discussing their counselling experiences, even though suicidality was the common context in all cases – and instead, they focused primarily on the counselling experiences themselves as that is what the interview questions mainly explored – this may have led to the identification of seemingly generic themes.

A second interpretation of this generality in thematic findings is that suicidal adolescents may not be a particularly unique population from a treatment perspective; overall, their counselling needs may overlap those of other adolescent clients or of clients in general. This idea is bolstered by the similarity between the findings of Everall and Paulson (2002) asserting the importance of the therapeutic alliance in counselling work with all adolescents, and the findings in my research. Likewise, Paulson and Everall (2003) remark that basic principles of counselling still apply "despite the individual's suicidality" (p. 319).

Polarized Views of Counselling Experiences

While completing the thematic analysis, I observed that in some cases, participants' counselling experiences were polarized in terms of helpfulness and unhelpfulness; in other words, participants seemed to dichotomize their counselling experiences into categories of either all good or all bad. This trend was evident both between different participants and within their individual stories; an example of the latter is provided by Matt's comments on two of his counselling encounters: "He [counsellor] wasn't good, actually I might even say he sucked" and "I think it [different counselling experience] was the greatest thing since sliced bread."

The polarity in described experiences may have been influenced by specific factors. First, participants' mental representation of life events, which in adolescence can incorporate various cognitive distortions (Everall et al., 2005), may have had an impact. For instance, a dichotomous thinking style may have led participants to categorize their counselling experiences in one of two extremes, and cognitive magnification may have predisposed participants to perceive the experiences in an

overly dramatic fashion, rather than to adopt a more balanced view of the encounters. This may help to explain Tina's initially negative perception of the counselling she received at the group home during early adolescence; she admitted that with further reflection over time – and presumably, cognitive changes resulting from maturation – her view of this counselling experience improved.

Alternatively, the polarity in participants' described experiences may have been due to the fact, first recognized by Beck (1972), that cognitive distortions are particularly evident during psychological distress. Thus, distress associated with suicidality and any related circumstances (e.g., depression or family dysfunction) may have led participants to mentally represent their subsequent counselling experiences in dichotomous terms or to overgeneralize a single negative incident in counselling. Furthermore, any distress experienced by participants in the research interviews due to anxiety or recalling experiences of suicidality and related life circumstances may have distorted their momentary representation of past counselling encounters.

The Disempowerment of Adolescents

In the previous chapter, Haven's counselling experiences were characterized as lacking in continuity and in having a heard voice; I speculated that such factors may result in a pervasive feeling of disempowerment in counselling. This strongly appeared to be the case for Haven, who, after many negative counselling experiences, seemed jaded and pessimistic about the worthwhileness of further counselling. Such a sense of disempowerment may lead adolescent clients to feel unable or unwilling to challenge any unhelpful counselling encounters, as described in the previous chapter and exemplified by Haven's comment that she "didn't really say anything [to object

to or complain about a negative counselling experience], because it was better than sitting in school for an afternoon." If adolescents feel disempowered in counselling, they may be likely to acquiesce and passively go along with the process because it is expedient to do so, given a perceived lack of other options.

Barbe et al. (2004) state that it is crucial to attend to feelings of hopelessness about treatment itself in depressed adolescent clients, as hopelessness can be a strong predictor of suicide. This makes me wonder if for some adolescents with a history of suicidality, a sense of disempowerment in counselling may lead to hopelessness about treatment and thus perhaps even continued suicidality, thus recreating the very state that the counselling is aiming to ameliorate. While such an outcome is speculative, Haven's case illustrates it anecdotally because she made a suicide attempt shortly after a counselling encounter that she perceived as very disempowering.

In society, suicidal teenagers are sometimes seen to be attention seekers, perhaps based on the common myth that their concerns are frivolous and flighty, and that they do not really need help. For example, Haven and Alicia both made suicide attempts for which they were treated in the hospital; however, according to these participants, no counselling or therapy was provided. This may reflect society's collective way of dealing, via denial or minimization, with the troubling issue of adolescent suicidality. However, this societal viewpoint may further disempower teenagers as a group by precluding their concerns from being taken seriously. Such disempowerment resulting from societal attitudes may cause adolescents additional distress by reinforcing the notion that they are unimportant.

In the previous chapter, I mused that adolescents tend to be disempowered in Western culture by virtue of being generally viewed as immature and irresponsible. However, while teenagers as a group may be thus disempowered, at the same time, there exist societal and peer pressures for adolescents on a more individual basis to become sophisticated as quickly as possible; for example, they may feel pressure to earn and to spend money, or to become sexually active. These paradoxical messages may add confusion or anguish to adolescents' quest for identity and may compound their psychological distress, which, for vulnerable teenagers, may even contribute to suicidality. The process of disempowerment in adolescence and the roles that both society and counselling play in this process require further research in the future.

New Knowledge Resulting From This Study

The findings of this research identify the importance of the therapeutic relationship in counselling work with suicidal adolescents. While it is well known that a significant portion of the variance in psychotherapy outcome is attributable to the therapeutic relationship (Martin, Garske, & Davis, 2000), this knowledge is based on the adult psychotherapy literature; its relevance to counselling work with teenage clients, and suicidal teenage clients specifically, is unclear. Moreover, few researchers have investigated the factors or processes involved in the building and maintenance of a satisfactory therapeutic relationship with suicidal adolescents. This study highlights the contribution of aspects such as counsellor openness and attunement to adolescent culture to the therapeutic relationship, and accordingly, to the outcome of counselling for the participants. It may be worthwhile to further explore such aspects and the role of the therapeutic relationship in counselling work with suicidal adolescents.

Secondly, the findings of this study raise interesting questions regarding the role that developmental issues may play in overcoming adolescent suicidality, as well as how they may impact the nature of the therapeutic encounter. There is a growing body of literature on the importance of the developmental tasks of adolescence (e.g., attachment and separation-individuation) within the counselling context (e.g., Everall, Bostik, & Paulson, 2005). In the current study, attachment with the counsellor seemed to be key for participants, so much so that its absence – as exemplified by the lack of continuity in counselling services that Haven experienced – led to the perception of unhelpful, perhaps even disempowering, experiences in counselling. Furthermore, developmental issues related to separation-individuation may have contributed to participants' preference for counsellors who were relatively close to them in age rather than parental figures. These findings add new dimension to the emergent literature on the significance of developmental tasks in adolescent suicidality.

Thirdly, the thread of Seeking Empowerment Through Connection was identified as tying together the findings in this study. The concept of empowerment has not been discussed in the adolescent suicide literature. While empowerment may be distantly related to the notion of locus of control – which has been investigated widely in relation to suicidality in adolescence, generally showing that an external locus of control orientation is associated with higher suicide risk (Evans, Owens, & Marsh, 2005) – the role that counselling may play in shifting suicidal adolescents' locus of control has not been studied. In addition, while the recent movement within psychotherapy promoting strength-based approaches identifies client empowerment as one goal (Johnson, 2003), the exact mechanisms of such a process remain unclear.

The findings in this study related to empowerment underscore the significance of suicidal teenagers' perception of having a voice about the course of their lives and realizing and building up of their inner resources, and they provide a building block for future research in this area.

A fourth contribution of this study to the existing knowledge base stems from the findings that suggest that the construct of direction in counselling is distinct from, and preferable to, directiveness as it is typically conceptualized in the literature. In particular, the theme that highlighted participants' need for direction in counselling appears to run counter to the tenets of the widely used client-centered approach, in which counsellors are taught to avoid being directive with clients. However, teenage clients generally do not know much about the counselling process; thus, they may need counsellors' assistance with conceptualizing goals for counselling and with structuring sessions via the topics discussed. Suicidal adolescents in particular may need such direction from counsellors. Therefore, the construct of direction differs in important ways from the notion of directiveness. These findings indicate that the counselling field may need to revisit the concept of a direction-focused style in counselling, at least in the context of work with suicidal adolescents.

Finally, the theme identifying participants' desire for counsellors to "reroute" the topic of suicidality in sessions brings attention to a neglected area in the literature. While counsellors are advised to ask direct questions doing the initial assessment of a client's suicide risk (Schwartz & Rogers, 2004), little information exists regarding how to handle the subject of suicidality in interventions that last beyond the initial

risk assessment. Therefore, an important finding in this study is the emphasis that participants placed on the manner in which suicidality is addressed in counselling.

Considerations

Several factors may have impacted the findings in this study and are discussed below. First, only one of the participants in this study is male. While it is well known that gender differences exist in the rates of adolescent suicide and attempted suicide (Joseph, 2003; Lester, 2003), it is less clear if teenage girls and boys have different needs in counselling following suicidality. The current study did not address gender differences in counselling experiences. However, Bae, Ye, Chen, Rivers, and Singh (2005), in a large scale analysis, found gender to be a differentiating characteristic in the identified risk and protective factors in adolescents' suicide attempts; the authors' recommendations imply the need for gender-specific treatments. Gender differences in suicidal adolescents' counselling requirements may well exist and merit research.

Secondly, participants' accounts of counselling experiences were dependent upon their memory of those experiences, and this memory was probably affected by the length of time that had elapsed since the experiences in question (which was up to several years in this study). Nevertheless, the current study is focused on participants' perceptions of their counselling experiences, rather than an exact historical account of those experiences. Indeed, a likely advantage in research of reliance on memory is that participants are likely to access their most salient experiences (Kraft, Glover, Dixon, Claiborn, & Ronning, 1985; Martin & Stelmaczonek, 1988).

Another issue related to the retrospective nature of the research design in this study is that shifts in participants' perceptions of their counselling experiences may

have occurred in the time span between the counselling and the research interviews. Because participants recounted experiences that had taken place a minimum of one year previously, the time interval (and any concomitant maturational processes) may have facilitated a new mental construction of these experiences to emerge. Any such new conceptualization may not accurately represent the experiences as they existed at the time of their occurrence; this is illustrated by Tina's report of a change over time in her evaluation of the helpfulness of a counselling experience. On the other hand, the time span between involvement in counselling and study participation may have allowed the participants to develop deeper reflection and insight regarding their counselling experiences, which would be desirable in the context of this study.

Implications for Counselling Practice

The findings of this study lead to some implications for counselling practice with suicidal adolescents. First, based on the centrality in participants' narratives of counsellors' interpersonal characteristics, specifically attentiveness, respectfulness, and genuineness, it seems important for counsellors to convey an overall sense of openness to their clients. This is likely to strengthen the therapeutic relationship, which is particularly important in interactions with suicidal teenagers (Paulson & Everall, 2003).

Secondly, some direction in counselling sessions on the part of the counsellor seems indicated. Based on the findings, this may involve incorporating guidance with respect to setting goals and directing the session topics. Adolescent clients are likely to have little prior knowledge of counselling or may hold misguided notions about counselling based on cultural myths and stereotypes. Therefore, explaining the goals

and methods of counselling can help to educate suicidal adolescents about the process of counselling; it may also increase their motivation and decrease any apprehension. Overall, the counsellor may need to incorporate direction so that the client knows the purpose and structure of counselling. Moreover, the findings imply that nondirective counselling approaches may not be appropriate for some suicidal adolescents.

A third implication is based on the finding that participants found certain counselling approaches to be unresponsive to their individual needs. Consequently, counsellors may consider attending to suicidal adolescents' individual needs related to their age, maturity, response to treatment, and personal preferences. This involves becoming aware of such client characteristics based on both objective and subjective assessment, for instance, via standardized instruments as well as phenomenological exploration of the client's lifeworld. Awareness of client needs can lead to greater responsiveness in the interventions utilized in counselling.

A fourth implication for counselling practice is that the overall atmosphere may need to be catered to fit the needs of suicidal adolescent clients. For participants, important elements of the atmosphere included proximity in age to the counsellor and suitability of the physical environment. Focusing on these factors individually yields some concrete suggestions for counselling practice. The age difference between the counsellor and the client is of course an immutable factor, however, as discussed previously, the participants' preference for a counsellor who is similar in age likely conveys a desire for a counsellor who is able to empathize with them and to join with the adolescent culture, without trying to behave like an adolescent – as Matt phrased it, "I don't think I would enjoy having my therapist dress up as Britney Spears" –

because this would likely diminish the genuineness in the therapeutic relationship. Such attunement to adolescent culture may involve trying to understand and showing interest in activities that teenagers typically enjoy or expressing interest in the hobbies and life experiences of each particular adolescent client.

The physical environment of counselling can also be altered to increase adolescent clients' sense that it is suitable. Participants objected to aspects of the physical environment such as lack of colour, décor that seemed too personal, and "little kids' stuff" or else excessive formality in the counselling setting. Instituting changes in this regard may help suicidal adolescent clients to feel more comfortable and thus more willing to engage with the counsellor.

To further facilitate the counselling process with suicidal adolescent clients, counsellors may need to examine how the topic of suicidality is dealt with in sessions. Participants expressed a desire for this topic to be addressed gently, without urgency or criticism, yet with patience and persistence. It seems imperative for counsellors to initiate and maintain open communication about the process of addressing suicidality with adolescent clients, in order to learn their preferences in this regard.

It was shown that some of the participants' experiences are reflective of a sense of disempowerment, and the process of how this sense can be influenced by variables in the therapeutic relationship was described. Moreover, disempowerment may lead to further distress for clients. As a result, it behooves counsellors working with suicidal adolescents to pay attention to the potential effects of the counselling process itself on the client, and to be aware that unhelpful aspects of the process (e.g.,

those that may result in a sense of disempowerment) may impede psychological recovery, or even propagate negative or destructive patterns in the client's life.

Finally, the findings of this study, being largely nonspecific in terms of their focus on suicidality, suggest that – other than the issue of addressing this subject in sessions – suicidal teenagers may not have particularly unique needs in counselling; although as discussed, their normal needs for connection or separation-individuation may be magnified. Therefore, counsellors may consider treating such clients as they would any other adolescent client. A counsellor who is competent in working with adolescents in general may already have the necessary skills and characteristics to work with adolescents who are suicidal; this implication may help to lessen the anxiety inherent in working with suicidal clients (Paulson & Everall, 2003).

Implications for Mental Health Care Administration

The findings of this study also have some implications for administration and policy planning in mental health care. One obvious implication is that, based on these and other research findings in regard to counselling work with suicidal adolescents, it is important to provide up to date training to counsellors working with these clients in order to optimize treatment. If the counselling needs of suicidal adolescents are not particularly unique, as has been hypothesized, counsellor training should address the specific counselling needs of adolescents in general and not just suicidal adolescents.

Another implication arises based on my finding of a lack of continuity in counselling services in participants' narratives. If this lack of continuity in services characterizes the experiences of suicidal adolescent clients in the community, it can and should be addressed at the administrative level. For instance, if this problem is

due to high employee turnover in counselling agencies, as implied by a few of the participants, then it may be targeted directly via increasing funding or attending to workstaff concerns, or it may be somehow circumvented (e.g., by providing group counselling facilitated by several leaders to maintain stability in service provision in case some counsellors leave). Furthermore, continuity of care should be ensured by making providers available to suicidal teenagers whose counselling was disrupted; this implies the need for secure funding for such circumstances.

Thirdly, my finding of a lack of feeling heard in participants' counselling experiences raises additional implications for mental health service administration. For instance, further research endeavours in counselling settings can aim to gather suicidal teenagers' views regarding their counselling needs. (While I did not ask the participants if being involved in my study helped them to feel heard, I suspect that this may have been one reason for their interest in participating.) Formally seeking input and feedback from suicidal adolescent clients may help to inform treatment approaches that will best serve these clients' needs.

Implications for Future Research

Research studies utilizing qualitative methods cannot be replicated in the strict sense of that word, due to the typically small sample sizes and variability in human responses on the part of both participants and researchers. However, research with similar participants and the use of similar or different methods can aim to seek out parallels between the findings. Such parallels would facilitate convergence among researchers in conceptualizing phenomena and thus increase trustworthiness of the findings. It would also be interesting to see future research focus on the counselling

experiences of specific subgroups of suicidal teenagers, for example, one gender or ethnicity, in order to study the ways in which such factors may impact the findings.

As illustrated by one participant's account, it may take the passage of time or cognitive maturation for adolescents to realize the value of a counselling experience. Therefore, it may be useful to track over time adolescent clients' perceptions of their counselling experiences in order to identify any changes that occur. Conroy (2003) asserts that such shifts should be studied in hermeneutic research. It may also prove useful to obtain more immediate perceptions of suicidal adolescents' experiences in counselling (i.e., by interviewing participants currently involved in counselling) and to compare these experiences to retrospective accounts, such as those in this study.

Further research is needed to investigate if suicidal adolescent clients have unique counselling experiences and needs, or if, as I have hypothesized based on the nonspecificity of the findings, they may be similar to the larger adolescent client population. If the latter is found to be true, future research with adolescent clients in general will help to further inform counselling practice with suicidal adolescents.

Personal Reflection on the Research Process and Findings

Due to the vicissitudes of life, my involvement in this study was intermittent; at several points in time, I was fully immersed in the research process, while at others, I suspended my involvement for several months at a time. This pattern proved to be both detrimental and advantageous in my role as researcher. Obviously, returning to the project after any lengthy interruption was difficult, as it necessitated reorienting myself to the work and picking up the analysis or writing process where it had been left off, and it was a challenge not to lose motivation with the loss of momentum.

On the other hand, I discovered that upon returning to the research, I often experienced an ability to uncover new patterns or meanings in participants' stories. While this may have been partly due to my development over time as a researcher and a clinician, I believe that it also represents the cognitive process of incubation, wherein solutions to a problem (such as the identification of subtleties in paradigm cases) become illuminated after some time away from the problem, as explicated by Wallas (1926) in his research on creativity. Because hermeneutic phenomenology is itself somewhat intuitive and creative, this approach was fortuitously complemented by my intermittent involvement in the study, which granted me greater insight and flexibility in analyzing the findings.

As Stuhlmiller (2001) notes, it is a privilege to bear witness to participants' stories of their experiences; this presents both challenges and rewards in the process and outcome of research. First, I found the task of writing participants' stories to be very laborious; in wanting to honour the participants' experiences, my goal was to succinctly capture their stories without omitting anything of relevance. Secondly, I found the process of uncovering themes and paradigm cases to be rather difficult at the beginning; like many neophyte qualitative researchers, I was overwhelmed with the amount of data before me. Thirdly, having spent the majority of my working time as a clinician, not a researcher, I felt impatient at times with the efforts required in interpretive research; this experience has been elucidated by Benner (1994).

After reflection and consultation, I decided to put my trust in the interpretive process, believing that insights or solutions would present themselves in time. In this regard, I believe that my concomitant development as a clinician facilitated my ability

to engage in a research enterprise that was frequently quite disjointed and ambiguous, much like the process of counselling tends to be. The beneficial relationship between my two professional roles was reciprocal; my growth as a researcher has also assisted my development as a clinician, particularly at times when I have been able to apply my learning from this study to my counselling work. One example of this is that, since becoming aware of participants' need for direction in counselling, I now regularly explore this issue with my adolescent clients and modify my approach in sessions accordingly.

Interpretive phenomenology invites reinterpretation of the researcher's prejudgments or presuppositions in light of the text (Heidegger, 1962, as cited in Stubblefield & Murray, 2002). Therefore, I wish to acknowledge how the study findings affected my own views of the subject matter. First, I discovered that the participants seemed motivated to engage in counselling, even if they presented the opposite image to their counsellors; for instance, in nearly every case, participants were quite willing to attend counselling and seemed to want to overcome suicidality, although they may have outwardly resisted and reacted to counselling by getting "all mad" as Alicia did. This speaks to the importance of patiently and explicitly attending to the client's experience of counselling over time, not just at the outset.

The findings of this study have also served to reinforce a belief that I held previously: the objective severity, or lack thereof, of an adolescent's self-injurious behaviours does not necessarily correlate with the intended outcome. For example, Alicia had repeatedly engaged in wrist cutting and medication overdoses that were minor enough to not need medical attention. This type of behaviour is usually viewed

as attention-seeking gestures rather than true suicide attempts, and thus not a serious matter; however, Alicia stated that she indeed intended to die via these methods. This reaffirms the value of asking research participants and clients about their subjective meanings and intents, as these may not be immediately transparent based on objective information. Incidentally, whether self-injurious behaviours are intended to result in death or not, I concur with Lowenstein (2005) who stresses that they should always be taken seriously and addressed, rather than dismissed.

Summary and Conclusion

This study provides rich retrospective descriptions of the counselling experiences of formerly suicidal adolescents and identifies common themes and meanings in these individuals' stories. Participants had both positive and negative experiences in counselling; the interpersonal qualities of counsellors, which conveyed openness and tied into the impact of the therapeutic relationship, were shown to play a critical role in their experiences. In addition, participants expressed their needs and desires for a sense of direction and a relational climate in counselling. On the other hand, they described feeling sometimes unattended to in counselling and objected to what they saw as a lack of responsiveness in certain counselling approaches. Finally, they generally wished to discuss the topic of suicidality with their counsellors in a gentle and indirect fashion, without minimization or avoidance of the topic.

Furthermore, some participants' counselling experiences were characterized by lack of continuity and lack of a heard voice, which led to the identification of the participants' feelings of expendability and muteness in counselling. These negative experiences contributed to a sense of disempowerment and personal insignificance.

The potential impact of such disempowerment on suicidal adolescents was discussed. Participants' empowering experiences in counselling, on the other hand, appeared to potentiate positive encounters with counsellors. The synthesis of the findings revealed within participants' narratives of counselling experiences the common thread of Seeking Empowerment Through Connection.

The findings were shown to have somewhat limited correspondence to the extant literature, due to the relative lack of research in this area. Generally, however, these findings parallel the recognized importance of the therapeutic relationship in counselling. They also introduce a conceptualization of direction in the context of counselling work with suicidal adolescents as distinct from – and preferable to – directiveness. This distinction is based on counsellor behaviours that relate to the developmental needs of adolescents with regard to attachment and separation-individuation – needs that may be particularly relevant for suicidal teenagers.

With current and future research yielding better knowledge outcomes of the counselling experiences and counselling needs of suicidal adolescents, understanding of the many factors contributing to teenage suicidality will be increased. In addition to informing treatment approaches, this understanding may improve professionals' ability to prevent adolescent suicidality from developing, worsening, or reoccurring. In other words, a better comprehension of adolescents' experiences of counselling following suicidality may offer additional useful information regarding the factors or processes that are important in the development and maintenance of suicidality. Such aspects can then be targeted at the levels of community screening and prevention, as well as at the level of treatment.

Upon suicidal adolescents' counselling experiences becoming better understood, prevention and treatment of adolescent suicidality can also be taken outside the arena of mental health intervention. Because adolescent suicidality is influenced by many risk and protective factors that frequently involve the systemic environment in which adolescents live, support and assistance can be solicited from the adolescents' educational and family systems. Indeed, teachers and parents often play an important role in teenagers' recovery from suicidality (Everall et al., 2006). Researchers and clinicians may thus need to focus on suicidal teenagers' holistic environments, and not just their individual involvement in counselling services.

The field of adolescent suicidology is most fertile. Based on the findings of this study alone, several implications for practice, administration, and future research have become unearthed. The findings of this study enrich current understanding of the counselling experiences of formerly suicidal adolescents, which may in turn help mental health professionals working in the field of adolescent suicidality to provide better treatment to their clients.

Perhaps the metaphor that was used earlier in this document to describe the participants' negative experiences in counselling – being stranded in a canoe in rough waters without a paddle – can also relate to the experiences of counsellors who work with suicidal adolescents. The existing research, which addresses mainly etiology and epidemiology of suicidality as opposed to treatment approaches, is of limited use to such counsellors; they too need a paddle. Further research related to the counselling experiences of suicidal adolescents may be the paddle necessary to empower counsellors to steer out of the currently unsettled waters in this area.

REFERENCES

Alvermann, D. E., O'Brien, D. G., & Dillon, D. R. (1996). On writing qualitative research. *Reading Research Quarterly, 31,* 114-120.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR®). Washington, DC: Author.

American Psychiatric Association (2003). Practice guidelines for the assessment and treatment of patients with suicidal behaviors. *Supplement to the American Journal of Psychiatry, 160*(11), 1-60.

Asarnow, J. R., Carlson, G. A., & Guthrie, D. (1987). Coping strategies, self-perceptions, hopelessness, and perceived family environments in depressed and suicidal children. *Journal of Consulting and Clinical Psychology, 55,* 361-366.

Asch, S. E. (1946). Forming impressions of personality. *Journal of Abnormal and Social Psychology, 41*, 258-290.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy, 28,* 534-549.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.

Bae, S., Ye, R., Chen, S., Rivers, P.A., & Singh, K.P. (2005). Risky behaviors and factors associated with suicide attempt in adolescents. *Archives of Suicide Research, 9*, 193-202.

Bagley, C., & Tremblay, P. (2000). Elevated rates of suicidal behavior in gay, lesbian, and bisexual youth. Crisis, 21, 111-117.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide.* Buckingham, UK: Open University Press.

Barbe, R.P., Bridge, J., Birhamer, B., Kolko, D., Brent, D.A. (2004). Suicidality and its relationship to treatment outcome in depressed adolescents. *Suicide and Life-Threatening Behavior, 34*, 44-55.

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence, 11*, 56-95.

Beck, A. T. (1972). *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania Press.

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationships between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *American Journal of Psychiatry, 147*(2), 190-195.

Beck, A. T., Steer, R. A., Beck, J. S., & Newman, C. F. (1993). Hopelessness, depression, suicidal ideation, and clinical diagnosis of depression. *Suicide and Life-Threatening Behavior, 23,* 139-145.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science, 8*, 1-14.

Benner, P. E. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. E. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health care and illness* (pp. 99-128). Thousand Oaks, CA: Sage.

Benner, P., Tanner, C. A., & Chesla, C. A. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer.

Bergum, V. (1991). Being a phenomenological researcher. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (Rev. ed., pp. 55-71). Newbury Park, CA: Sage.

Berman, A. L. (1987). Adolescent suicide: Clinical consultation. *Clinical Psychologist, 40,* 87-90.

Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Bland, R. C., Dyck, R. J., Newman, S. C., & Orn, H. (1998). Attempted suicide in Edmonton. In A. A. Leenaars et al. (Eds.), *Suicide in Canada* (pp. 136- 150). Toronto, Canada: University of Toronto.

Bobrow, R. S. (2002). Sexual orientation and suicide risk among teenagers. *Journal of the American Medical Association, 287*, 1265-1266.

Boergers, J., Spirito, A., & Donaldson, D. (1998). Reasons for adolescent suicide attempts: Associations with psychological functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1287-1293.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16,* 252-260.

Brent, D. A. (2004). Antidepressants and pediatric depression: The risk of doing nothing. *New England Journal of Medicine, 351*, 1598-1601.

Brent, D.A. (2005). Is the medication bottle for pediatric and adolescent depression half-full or half-empty? *Journal of Adolescent Health, 37*, 431-433.

Brent, D. A., & Apter, A. (2003). Adolescent suicide and suicidal behavior: A time to assess and a time to treat. *Israel Journal of Psychiatry and Related Sciences, 40*, 159-162.

Brent, D. A., Johnson, B. A., Perper, J., Connolly, J., Bridge, J., Bartle, S., et al. (1994). Personality disorder, personality traits, impulsive violence, and completed suicide in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 33,* 1080-1086.

Brent, D. A., Perper, J. A., Goldstein, C. E., Kolko, D. J., Allan, M. J., Allman, C. J., et al. (1988). Risk factors for adolescent suicide: A comparison of adolescent suicide victims with suicidal inpatients. *Archives of General Psychiatry, 45,* 581-588.

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Schweers, J., Balach, L., et al (1994). Familial risk factors for adolescent suicide: A case-control study. *Acta Psychiatrica Scandinavica, 89,* 52-58.

Breton, J.-J., Boyer, R., Bilodeau, H., Raymond, S., Joubert, N., & Nantel, M.-A. (2002). Is evaluative research on youth suicide programs theory-driven? The Canadian experience. *Suicide and Life-Threatening Behavior, 32*, 176-191.

Brevard, A., Lester, D., & Yang, B. (1990). A comparison of suicide notes written by suicide completers and suicide attempters. *Crisis, 11,* 7-11.

Burge, V., Felts, M., Chenier, T., & Parrillo, A. V. (1995). Drug use, sexual activity, and suicidal behavior in U.S. high school students. *Journal of School Health, 65,* 222-227.

Canadian Psychological Association (2000). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa, Canada: Author.

Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35,* 191-219.

Churchill, S. D. (2000). Phenomenological psychology. In A. Kazdin (Ed.), *Encyclopaedia of psychology*. New York: American Psychological Association and Oxford University Press.

Cole, D. A. (1989). Psychopathology of adolescent suicide: Hopelessness, coping beliefs, and depression. *Journal of Abnormal Psychology, 98,* 248-255.

Collins, S., & Cutcliffe, J. R. (2003). Addressing hopelessness in people with suicidal ideation: Building upon the therapeutic relationship utilizing a cognitive behavioural approach. *Journal of Psychiatric and Mental Health Nursing, 10,* 175-185.

Conroy, S.A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods, 2*(3). Article 4. Retrieved May 5, 2006 from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/conroy.pdf

Corey, G. (1991). *Theory and practice of counseling and psychotherapy.* Boston: Allyn and Bacon.

Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52,* 202-205.

Crook, M. (2003). *Out of the darkness: Teens talk about suicide*. Vancouver, Canada: Arsenal Pulp Press.

Cutcliffe, J. R. (2003). Research endeavours into suicide: A need to shift the emphasis. *British Journal of Nursing, 12*(2), 92-99.

Cutcliffe, J. R. (2005). Toward an understanding of suicide in First-Nation Canadians. *Crisis, 26,* 141-145.

Cutcliffe, J. R., & McKenna, H. P. (2002). When do we know what we know? Considering the truth of research findings and the craft of qualitative research. *International Journal of Nursing Studies, 39,* 611-618.

Cutcliffe, J. R., & McKenna, H. P. (2004). Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing, 45,* 126-135.

Cutcliffe, J. R., & Ramcharan, P. (2002). Leveling the playing field? Exploring the merits of the ethics-as-process approach for judging qualitative research proposals. *Qualitative Health Research, 12,* 1000-1010.

Daniels, J. A. (1990). Adolescent separation-individuation and family transitions. *Adolescence, 25*, 105-116.

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied and Preventive Psychology, 5,* 85-100.

Doctors, S. R. (2000). Attachment-individuation: I. Clinical notes toward a reconsideration of "adolescent turmoil." In A. H. Esman, L. T. Flaherty, & H. A. Horowitz (Eds.), *Adolescent psychiatry: Developmental and clinical studies, Vol. 25* (pp. 3-16). Hillsdale, NJ: Analytic Press.

Dowling, M. (2007). From Husserl to van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies, 44,* 131-142.

Downey, A. (1990). The impact of drug abuse upon adolescent suicide. *Omega, 22,* 261-275.

Eddins, C. L., & Jobes, D. A. (1994). Do you see what I see? Patient and clinician perceptions of underlying dimensions of suicidality. *Suicide and Life-Threatening Behavior, 24,* 170-173.

Elliott, G. C., Colangelo, M. F., & Gelles, R. J. (2005). Mattering and suicide ideation: Establishing and elaborating a relationship. *Social Psychology Quarterly, 68*, 223-238.

Elliott, R. & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9,* 442-467.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York: Norton.

Evans, W. P., Owens, P., & Marsh, S. C. (2005). Environmental factors, locus of control, and adolescent suicide risk. *Child & Adolescent Social Work Journal, 22,* 301-319.

Evans, W., Smith, M., Hill, G., Albers, E., & Neufeld, J. (1996). Rural adolescent views of risk and protective factors associated with suicide. *Crisis Intervention and Time-Limited Treatment, 3,* 1-12.

Everall, R. D. (2000). The meaning of suicide attempts by young adults. *Canadian Journal of Counselling, 34,* 111-125.

Everall, R. D., Altrows, K. J., & Paulson, B. L. (2006). Creating a future: A study of resilience in suicidal adolescents. *Journal of Counseling and Development, 84,* 461-470.

Everall, R. D., Bostik, K. E., & Paulson, B. L. (2005). I'm sick of being me: Developmental themes in a suicidal adolescent. *Adolescence, 40,* 693-708.

Everall, R. D., & Paulson, B. L. (2001). The Teen Suicide Research project. *Alberta Journal of Educational Research, 47*(1), 91-94.

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research, 2*(2), 78-87.

Follesdal, D. (2001). Hermeneutics. *International Journal of Psychoanalysis, 82,* 375-379.

Forman, S. G., & Kalafat, J. (1998). Substance abuse and suicide: Promoting resilience against self-destructive behavior in youth. *School Psychology Review, 27,* 398-407.

Gartrell, J. W., Jarvis, G. K., & Derksen, L. (1993). Suicidality among adolescent Alberta Indians. *Suicide and Life-Threatening Behavior, 23,* 366-373.

Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care, 9,* 114-122.

Gould, M. S., Shaffer, D., Fisher, P., & Garfinkel, R. (1998). Separation/divorce and child and adolescent completed suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 155-162.

Greenberg, L. S. (1999). Ideal psychotherapy research: A study of significant change processes. *Journal of Clinical Psychology, 55,* 1467-1480.

Groves, S. A., & Sher, L. (2005). Gender differences in suicidal behavior and alcohol abuse in adolescents. *International Journal of Adolescent Medicine and Health, 17,* 307-308.

Guba, E. C., & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco, CA: Jossey-Bass.

Gubrium, J. F. (1995). Taking stock. *Qualitative Health Research, 5,* 267-269.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18,* 59-82.

Gutierrez, P. M., Muehlenkamp, J. J., Konick, L. C., & Osman, A. (2005). What role does race play in adolescent suicidal ideation? *Archives of Suicide Research, 9,* 177-192.

Hanna, F. J., Hanna, C. A., & Keys, S. G. (1999). Fifty strategies for counseling defiant, aggressive adolescents: Reaching, accepting, and relating. *Journal of Counseling and Development, 77,* 395-404.

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology, 52,* 146-155.

Hazell, P. (1993). Adolescent suicide clusters: Evidence, mechanisms, and prevention. *Australia and New Zealand Journal of Psychiatry, 30,* 633-642.

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological Methods, 6,* 3-17.

Hendin, H. (1987). Youth suicide: A psychosocial perspective. *Suicide and Life-Threatening Behavior, 17,* 151-165.

Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly, 19,* 139-150.

Henriques, G., Beck, A. T., & Brown, G. K. (2003). Cognitive therapy for adolescent and young adult suicide attempters. *American Behavioral Scientist, 46,* 1258-1268.

Henry, C. S., Stephenson, A. L., Fryer Hanson, M., & Hargett, W. (1994). Adolescent suicide and families: An ecological approach. *Family Therapy, 21,* 63-80.

Hinck, S. (2004). The lived experience of oldest-old rural adults. *Qualitative Health Research, 14,* 779-791.

Hoover, M. A. & Paulson, B. L. (1999). Suicidal no longer. *Canadian Journal of Counselling, 33,* 227-245.

Horesh, N., Rolnick, T., Iancu, I., Dannon, P., Lepkifker, E., Apter, A., et al. (1996). Coping styles and suicide risk. *Acta Psychiatrica Scandinavica, 93,* 489-493.

Huffine, C. L. (1991). Social and cultural risk factors for youth suicide. In L. Davidson & M. Linnoila (Eds.), *Risk factors for youth suicide* (pp. 40-54). New York: Hemisphere.

Hughes, S. L., & Neimeyer, R. A. (1990). A cognitive model of suicidal behavior. In D. Lester (Ed.), *Current concepts of suicide* (pp. 1-28). Philadelphia: Charles Press.

Hulten, A., & Wasserman, D. (1998). Lack of continuity: A problem in the care of young suicides. *Acta Psychiatrica Scandinavica, 79,* 326-333.

Jobes, D. A., Berman, A. L., & Martin, C. E. (2005). Adolescent suicidality and crisis intervention. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed.) (pp. 395-415). New York: Oxford University Press.

Joe, S., & Marcus, S. C. (2003). Datapoints: Trends by race and gender in suicide attempts among U.S. adolescents, 1991-2001. *Psychiatric Services, 54,* 454.

Johnson, N. G. (2003). On treating adolescent girls: Focus on strengths and resiliency in psychotherapy. *Journal of Clinical Psychology, 59,* 1193-1203.

Joseph, H. B., Reznick, I., & Mester, R. (2003). Suicidal behavior of adolescent girls: Profile and meaning. *Israel Journal of Psychiatry and Related Sciences, 40,* 209-219.

Kazdin, A. E. (1990). Psychotherapy for children and adolescents. *Annual Review of Psychology, 41,* 21-54.

Kienhorst, C. W. M., De Wilde, E. J., & Diekstra, R. F. W. (1994). Suicidal behaviour in adolescents. *Archives of Suicide Research, 1,* 185-209.

Kienhorst, C. W. M., De Wilde, E. J., Diekstra, R. F. W., & Wolters, W. H. G. (1992). Differences between adolescent suicide attempters and depressed adolescents. *Acta Psychiatrica Scandinavica, 85,* 222-228.

Kienhorst, C. W. M., De Wilde, E. J., Diekstra, R. F. W., & Wolters, W. H. G. (1995). Adolescents' image of their suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 623-628.

King, C. A. (1997). Suicidal behavior in adolescence. In R. W. Maris, M. M. Silverman, & S. S. Canetto (Eds.), *Review of suicidology* (pp. 61-95). New York: Guilford Press.

Kirmayer, L. J., Malus, M., & Boothroyd, L. J. (1996). Suicide attempts among Inuit youth: A community survey or prevalence and risk factors. *Acta Psychiatrica Scandinavica, 94,* 8-17.

Klein, P., & Westcott, M. R. (1994). The changing character of phenomenological psychology. *Canadian Psychology, 35,* 133-158.

Kosky, R., Silburn, S., & Zubrick, S. R. (1990). Are children and adolescents who have suicidal thoughts different from those who attempt suicide? *The Journal of Nervous and Mental Disease, 178,* 38-43.

Kotila, L., & Loennqvist, J. (1987). Adolescents who make suicide attempts repeatedly. *Acta Psychiatrica Scandinavica, 76,* 386-393.

Kraft, R. G., Glover, J. A., Dixon, D. N., Claiborn, C. D., & Ronning, R. R. (1985). Memory research in counseling: A perspective and some hypotheses. *Counselor Education and Supervision, 25,* 122-133.

Krarup, G., Nielsen, B., Rask, P., & Petersen, P. (1991) Childhood experiences and repeated suicidal behavior. *Acta Psychiatrica Scandinavica, 83,* 16-19.

Kuzel, A. J. (1999). Sampling in qualitative inquiry. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Lambert, M., Bergin, A., & Garfield, S. (2004). Introduction and historical overview. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th edition) (pp. 3-15). New York: John Wiley & Sons.

Langlois, S., & Morrison, P. (2002). *Suicide deaths and attempts: Canadian social trends. Autumn 2002* (Catalogue No. 11-008). Ottawa, Canada: Statistics Canada.

Leenaars, A. A. (1994). Crisis intervention with highly lethal suicidal people. *Death Studies, 18,* 341-360.

Leenaars, A. A. (1997). Rick: A suicide of a young adult. *Suicide and Life-Threatening Behavior, 27,* 15-27.

Leenaars, A. A. (2004). *Psychotherapy with suicidal people: A person-centred approach.* Hoboken, NJ: John Wiley & Sons.

Leenaars, A. A. (2006). Psychotherapy with suicidal people: The commonalities. *Archives of Suicide Research, 10,* 305-322.

Leenaars, A. A., & Lester, D. (1990). Suicide in adolescents: A comparison of Canada and the United States. *Psychological Reports, 67,* 867-873.

Leenaars, A. A., & Lester, D. (1994). Suicide and homicide rates in Canada and the United States. *Suicide and Life-Threatening Behavior, 24,* 184-191.

Lester, D. (1990). Suicide across the life span: A look at international trends. In A. Leenaars (Ed.), *Life-span perspective of suicide* (pp. 71-80). New York: Plenum/Human Sciences.

Lester, D. (2003). Adolescent suicide from an international perspective. *American Behavioral Scientist, 46,* 1157-1170.

Lester, D. (2005). On being happy that someone has committed suicide. *Crisis, 26,* 95-96.

Lowenstein, L. F. (2005). Youths who intentionally practice self-harm: Review of the recent research 2001-2004. *International Journal of Adolescent Medicine and Health, 17,* 225-230.

Lowes, L., & Prowse, M. A. (2001) Standing outside the interview process? The illusion of objectivity in phenomenological data generation. *International Journal of Nursing Studies, 38,* 471-480.

Luborsky, L., McLellan, A., Woody, G., O'Brien, C., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42,* 602-611.

Mackey, S. (2005). Phenomenological nursing research: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies, 42*, 179-186.

Maples, M. F., Packman, J., Abney, P., Daugherty, R. F., Casey, J. A., & Pirtle, L. (2005). Suicide by teenagers in middle school: A postvention team approach. *Journal of Counseling and Development, 83*, 397-405.

March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., et al. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*, 807-820.

Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive textbook of suicidology.* New York: Guildford Press.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438-450.

Martin, J., & Stelmaczonek, K. (1988). Participants' identification and recall of important events in counselling. *Journal of Counseling Psychology, 35*, 385-390.

Mazza, J. J. (2000). The relationship between posttraumatic stress symptomatology and suicidal behavior in school-based adolescents. *Suicide and Life-Threatening Behavior, 30,* 91-103.

Mazza, J. J., & Reynolds, W. M. (2001). An investigation of psychopathology in nonreferred suicidal and nonsuicidal adolescents. *Suicide and Life-Threatening Behavior, 31,* 282-302.

McFarland, W. P. (1998). Gay, lesbian, and bisexual student suicide. *Professional School Counseling, 1,* 26-29.

McKeown, R. E., Garrison, C. Z., Cuffe, S. P., Waller, J. L. Jackson, K. L., & Addy, C. L. (1998). Incidence and predictors of suicidal behaviors in a longitudinal sample of young adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 612-619.

Meeus, W. (1996). Studies on identity development in adolescence: An overview of research and some new data. *Journal of Youth and Adolescence, 25,* 569-597.

Merriam, S. B. (2002). *Qualitative Research in Practice: Examples for Discussion and Analysis.* San Francisco: Jossey-Bass.

Miller, K. E., King, C. A., Shain, S. N., & Naylor, M. W. (1992). Suicidal adolescents' perceptions of their family environment. *Suicide and Life-Threatening Behavior, 22,* 226-239.

Mitchell, J. J. (1992). *Adolescent struggle for selfhood and identity.* Calgary, Alberta: Detselig Enterprises.

Morano, C. D., Cisler, R. A., & Lemerond, J. (1993). Risk factors for adolescent suicidal behavior: Loss, insufficient familial support, and hopelessness. *Adolescence, 28,* 851-865.

Morris, R. J., & Nicholson, J. (1993). The therapeutic relationship in child and adolescent psychotherapy: Research issues and trends. In T. R. Kratochwill & R. J. Morris (Eds.), *Handbook of psychotherapy with children and adolescents* (pp. 405-425). Boston: Allyn & Bacon.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260.

Moskos, M. A., Achilles, J., & Gray, D. (2004). Adolescent suicide myths in the United States. *Crisis, 25,* 176-182.

Moskos, M., Olson, L., Halbern, S., Keller, T., & Gray, D. (2005). Utah Youth Suicide Study: Psychological autopsy. *Suicide and Life-Threatening Behavior, 35,* 536-546.

Moules, N. J. (2001). Hermeneutic inquiry: Paying heed to history and Hermes – An ancestral, substantive, and methodological tale. *International Journal of Qualitative Methods, 1*(3), Article 1. Retrieved April 15, 2003 from http://www.ualberta.ca/~ijqm//

Muehlenkamp, J. J., & Gutierrez, P. M. (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of adolescents. *Suicide and Life-Threatening Behavior, 34,* 12-22.

Munhall, P. L. (1988). Ethical considerations in qualitative research. *Western Journal of Nursing Research, 10,* 150-162.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26,* 237-252.

Ochberg, R. L. (1996). Interpreting life stories. In R. Josselson (Ed.), *Ethics and process in the narrative study of lives* (pp. 97-113). Thousand Oaks, CA: Sage.

Oejehagen, A., Regnell, G., & Traeskman-Bendz, L. (1991). Deliberate self-poisoning: Repeaters and nonrepeaters admitted to an intensive care unit. *Acta Psychiatrica Scandinavica, 84,* 266-271.

Olfson, M., Shaffer, D., Marcus, S. C., & Greenberg, T. (2003). Relationship between antidepressant medication treatment and suicide in adolescents. *Archives of General Psychiatry, 60,* 978-982.

Oliver, K. L. (1998). A journey into narrative analysis: A methodology for discovering meanings. *Journal of Teaching in Physical Education, 17,* 244-259.

Orbach, I., & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping. *Suicide and Life-Threatening Behavior, 23,* 120-129.

Pagliaro, L. A. (1995). Adolescent depression and suicide: A review and analysis of the current literature. *Canadian Journal of School Psychology, 11,* 191-201.

Paterson, M., & Higgs, J. (2005). Using hermeneutics as a qualitative research approach in professional practice. *The Qualitative Report, 10,* 339-357. Retrieved January 5, 2006 from http://www.nova.edu/ssss/QR/QR10-2/paterson.pdf

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Paulson, B. L., & Everall, R. D. (2003). Suicidal adolescents: Helpful aspects of psychotherapy. *Archives of Suicide Research, 7*, 1-13.

Paulson, B. L., Everall, R. D., & Stuart, J. (2001). Client perceptions of hindering experiences in counseling. *Counselling and Psychotherapy Research, 1*, 53-61.

Paulson, B. L., & Worth, M. (2002). Counseling for suicide: Client perspectives. *Journal of Counseling and Development, 80*, 86-93.

Pelkonen, M., & Marttunen, M. (2003). Child and adolescent suicide: Epidemiology, risk factors, and approaches to prevention. *Pediatric Drugs, 5*, 243-265.

Pfeffer, C. R. (1996). Suicidal behavior as a response to stress. In C. R. Pfeffer (Ed.), *Severe stress and mental disturbance in children* (pp. 327-436). Washington, DC: American Psychiatric Press.

Poijula, S., Wahlberg, K.-E., & Dyregrov, A. (2001). Adolescent suicide and suicide contagion in three secondary schools. *International Journal of Emergency Mental Health, 3*, 163-168.

Polkinghorne, D. E. (1994). Narrative approaches in psychology: Theories, methods, and applications. *History and Philosophy of Psychology Bulletin, 6(2),* 12-18.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *Qualitative Studies in Education, 8,* 5-23.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52,* 137-145.

Pompili, M., Tatarelli, R., & Lester, D., (2005). The prevention of suicide is everybody's business: Willing is not enough, we must do. *Minerva Psichiatrica, 46*, 145-146.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126-136.

Popenhagen, M. P., & Qualley, R. M. (1998). Adolescent suicide: Detection, intervention, and prevention. *Professional School Counseling, 1,* 30-36.

Portes, P. R., Sandhu, D. S., & Longwell-Grice, R. (2002). Understanding adolescent suicide: A psychosocial interpretation of developmental and contextual factors. *Adolescence, 37,* 805-814.

Racher, F. E., & Robinson, S. (2003). Are phenomenology and postpositivism strange bedfellows? *Western Journal of Nursing Research, 25,* 464-481.

Rak, C. F. (2002). Heroes in the nursery: Three case studies in resilience. *Journal of Clinical Psychology, 58,* 247-260.

Ramcharan, P., & Cutcliffe, J. R. (2001). Judging the ethics of qualitative research: Considering the 'ethics as process' model. *Health and Social Care in the Community, 9,* 358-366.

Raskin, N. (1978). Becoming: A therapist, a person, a partner, and a parent. *Psychotherapy: Theory, Research and Practice, 4,* 362-370.

Raskin, N. J., & Rogers, C. R. (1995). Person-centered therapy. In R. J. Corsini & D. Wedding (Eds.), *Current Psychotherapies* (5th ed.) (pp. 128-161). Itasca, Illinois: F. E. Peacock.

Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicidal and Life-Threatening Behavior, 32,* 146-157.

Reith, D. M., Whyte, I., Carter, G., & McPherson, M. (2003). Adolescent self-poisoning: A cohort study of subsequent suicide and premature deaths. *Crisis, 24,* 79-84.

Remafedi, G. (1999). Sexual orientation and youth suicide. *Journal of the American Medical Association, 282,* 1291-1292.

Rhodes, A. E., & Links, P. S. (1998). Suicide and suicidal behaviours: Implications for mental health services. *Canadian Journal of Psychiatry, 43,* 785-791.

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park, CA: Sage.

Roberts, R. E., Roberts, C. R., & Chen, Y. R. (1998). Suicidal thinking among adolescents with a history of attempted suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1294-1300.

Rogde, S., Hougen, H. P., & Poulsen, K. (1996). Suicides in two Scandinavian capitals: A comparative study. *Forensic Science International, 80,* 211-219.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Psychology, 21*, 1294-1300.

Rogers, J. R. (2001). Theoretical grounding: The "missing link" in suicide research. *Journal of Counseling and Development, 79*, 16-25.

Rogers, J. R., & Soyka, K. M. (2004). "One size fits all": An existential-constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy, 34*, 7-22.

Rotheram-Borus, M. J., & Trautman, P. D. (1988). Hopelessness, depression, and suicidal intent among adolescent suicide attempters. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 700-704.

Rubenstein, J. L., Halton, A., Kasten, L, Rubin, C., & Stechler, G. (1998). Suicidal behavior in adolescents: Stress and protection in different family contexts. *American Journal of Orthopsychiatry, 68*, 274-284.

Rubenstein, J. L., Heeren, T., Housman, D., Rubin, C., & Stechler, G. (1989). Suicidal behavior in "normal" adolescents: Risk and protective factors. *American Journal of Orthopsychiatry, 59*, 59-71.

Rudd, M. D. (2003). Warning signs for suicide? *Suicide and Life-Threatening Behavior, 33*, 99-100.

Rudd, M. D., Joiner, T., & Rajab, M. H. (2001). *Treating suicidal behavior: An effective, time-limited approach.* New York: Guilford Press.

Russel, S. T., & Joiner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91*, 1276-1281.

Safer, D. J. (1997a). Adolescent/adult differences in suicidal behavior and outcome. *Annals of Clinical Psychiatry, 9*, 61-66.

Safer, D. J. (1997b). Self-reported suicide attempts by adolescents. *Annals of Clinical Psychiatry, 9*, 263-269.

Sakinofsky, I., & Leenaars, A. A. (1997). Suicide in Canada with special reference to the difference between Canada and the United States. *Suicide and Life-Threatening Behavior, 27*, 112-126.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18*, 179-183.

Schaffer, D., & Pfeffer, C. R. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 24S-51S.

Schwartz, R. C., & Rogers, J. R. (2004). Suicide assessment and evaluation strategies: A primer for counselling psychologists. *Counselling Psychology Quarterly, 17,* 89-97.

Sher, L., Kandel., I., & Merrick, J. (2006). Alcohol and suicidal behavior in adolescents: A medical and social problem. *International Journal of Adolescent Medicine and Health, 18*, 1-2.

Sher, L., & Zalsman, G. (2005). Alcohol and adolescent suicide. *International Journal of Adolescent Medicine and Health, 17*, 197-203.

Shneidman, E. (1985). *Definition of suicide.* New York: Wiley.

Shneidman, E. (1993). Some controversies in suicidology: Toward a mentalistic discipline. *Suicide and Life-Threatening Behavior, 23*, 292-298.

Smith, C. P. (2000). Content analysis and narrative analysis. In H. R. Reis & C. M. Judd (Eds.), *Handbook of research methods in social and personality psychology* (pp. 313-335). Cambridge: University Press.

Smokowski, P. R., Reynolds, A. J., & Bezruczko, N. (1999). Resilience and protective factors in adolescence: An autobiographical perspective from disadvantaged youth. *Journal of School Psychology, 37*, 425-448.

Smythe, W. E., & Murray, M. J. (2000). Owning the story: Ethical considerations in narrative research. *Ethics and Behavior, 10*, 311-336.

Spruijt, E., & de Goede, M. (1997). Transitions in family structure and adolescent well-being. *Adolescence, 32*, 896-911.

Stanton, C., Spirito, A., Donaldson, D., & Boergers, J. (2003). Risk-taking behavior and adolescent suicide attempts. *Suicide and Life-Threatening Behavior, 33*, 74-79.

Statistics Canada (2006). *Suicides and suicide rate, by sex and by age group* [On-line]. Retrieved July 2, 2006 from: http://www40.statcan.ca/l01/cst01/perhlth66a.htm

Stillion, J. M., & McDowell, E. E. (1996). *Suicide across the life span: Premature exits* (2nd ed.). Washington, DC: Taylor and Francis.

Stoelb, M., & Chiriboga, J. (1998). A process model for assessing adolescent risk for suicide. *Journal of Adolescence, 21*, 359-370.

Stubblefield, C., & Murray, R. L. (2002). A phenomenological framework for psychiatric nursing research. *Archives of Psychiatric Nursing, 16*, 149-155.

Stuhlmiller, C. M. (2001). Narrative methods in qualitative research: Potential for therapeutic transformation. In K. R. Gilbert (Ed.), *The emotional nature of qualitative research* (pp. 63-80). Boca Raton, FL: CRC Press.

Suokas, J., & Loennqvist, J. (1991). Outcome of attempted suicide and psychiatric consultation: Risk factors and suicide mortality during a five-year follow-up. *Acta Psychiatrica Scandinavica, 84,* 545-549.

Thompson, E. A., Mazza, J. J., Herting, J. R., Randell, B. P., & Eggert, L. L. (2005). The mediating roles of anxiety, depression, and hopelessness on adolescent suicidal behaviors. *Suicidal and Life-Threatening Behavior, 35,* 14-34.

Tiller, J., Kupinski, J., Burrows, G., Mackenzie, A., Hallenstein, H., & Johnston, G. (1998). Completed and attempted youth suicide in Victoria. *Stress Medicine, 14*, 249-254.

Truscott, D., Evans, J., & Knish, S. (1999). A process model for clinical decision making in high-risk outpatient situations: The therapeutic alliance and suicide. *Canadian Journal of Counselling*, 33, 307-316.

University of Alberta (2002). *Standards for the protection of human research participants* [On-line]. Available: www.uofaweb.ualberta.ca/gfcpolicymanual/content.cfm?ID_page=37738

Usher, K. J., & Arthur, D. (1998). Process consent: A model for enhancing informed consent in mental health nursing. *Journal of Advanced Nursing, 27,* 692-697.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Canada: Althouse Press.

Wagner, B. M., Wong, S. A., & Jobes, D. A. (2002). Mental health professionals' determinations of adolescent suicide attempts. *Suicide and Life-Threatening Behavior, 32*, 284-300.

Wallas, G. (1926). *Art of thought*. London: J. Cape.

Watkins, R. L., & Gutierrez, P. M. (2003). The relationship between exposure to adolescent suicide and subsequent suicide risk. *Suicide and Life-Threatening Behavior, 33*, 21-32.

Webster, D. W., Vernick, J. S., Zeoli, A. M., & Manganello, J. A. (2004). Association between youth-focused firearm laws and youth suicides. Journal of the American Medical Association, 292, 594-601.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52,* 167-177.

Yang, B., & Clum, G. A. (1996). Effects of early negative life experiences on cognitive functioning and risk for suicide: A review. *Clinical Psychology Review, 16*, 177-195.

Zalsman, G., & Mann, J. J. (2005). The neurobiology of suicide in adolescents: An emerging field of research. *International Journal of Adolescent Medicine and Health, 17*, 195-196.

APPENDIX A: PURPOSE OF THE STUDY FORMS

Purpose of the Study for Participants

The Counselling Experiences of Suicidal Adolescents

Researcher: Agatha Beschell, MSc 492-5350

Research Supervisor: Robin Everall, PhD 492-1163

Department of Educational Psychology, University of Alberta

This research is the basis of Agatha Beschell's doctoral dissertation. The purpose of the study is to gather information about suicidal teenagers' counselling experiences. This topic has not been addressed by research done to date. Increased knowledge and understanding of these counselling experiences will be useful to counsellors working with teenagers who are experiencing suicidal thoughts, feelings, and behaviours.

Participants will be asked to discuss their experiences of being suicidal, and of the counselling that they received, in an individual interview lasting one to two hours. The interview will be audio-taped in order to be transcribed into text format. At a later time, participants will be contacted and given the choice to review the written account of their experiences and to provide additional information, if they wish.

Participation is voluntary, therefore, participants have the right to withdraw participation at any time without penalty. Participants' confidentiality and anonymity will be protected through the use of pseudonyms (false names) and alteration of identifying information. If participants experience distress as a result of discussing these topics, counselling referrals will be provided to them.

Questions or concerns regarding any aspect of this research can be directed to me, Agatha Beschell, or to my research supervisor, Dr. Robin Everall, at the numbers listed above; or, you can e-mail me at 'agatha@ualberta.ca'.

Purpose of the Study for Parents/Legal Guardians

The Counselling Experiences of Suicidal Adolescents

Researcher: Agatha Beschell, MSc 492-5350

Research Supervisor: Robin Everall, PhD 492-1163

Department of Educational Psychology, University of Alberta

This research is the basis of Agatha Beschell's doctoral dissertation. The purpose of the study is to gather information about suicidal teenagers' counselling experiences. This topic has not been addressed by research done to date. Increased knowledge and understanding of these counselling experiences will be useful to counsellors working with teenagers who are experiencing suicidal thoughts, feelings, and behaviours.

Participants will be asked to discuss their experiences of being suicidal, and of the counselling that they received, in an individual interview lasting one to two hours. The interview will be audio-taped in order to be transcribed into text format. At a later time, participants will be contacted and given the choice to review the written account of their experiences and to provide additional information, if they wish.

Participation is voluntary, therefore, participants and their parents/legal guardians have the right to withdraw participation at any time without penalty. Participants' confidentiality and anonymity will be protected through the use of pseudonyms (false names) and alteration of identifying information. If participants experience distress as a result of discussing these topics, counselling referrals will be provided to them.

Questions or concerns regarding any aspect of this research can be directed to me, Agatha Beschell, or to my research supervisor, Dr. Robin Everall, at the numbers listed above; or, you can e-mail me at 'agatha@ualberta.ca'.

APPENDIX B: INFORMED CONSENT/ASSENT FORMS

Informed Consent Form for Participants

You are being asked to participate in a research study entitled "The Counselling Experiences of Suicidal Adolescents" being carried out by Agatha Beschell under the supervision of Dr. Robin Everall at the Department of Educational Psychology at the University of Alberta. Verbal and written descriptions of the study have been provided to you. If you have any questions or concerns, please feel free to address them at any time.

In an interview, you will be asked to discuss your experience of being suicidal and your experience of the counselling which you received in relation to being suicidal. This is a voluntary project, therefore, you have the right to withdraw your participation at any time without penalty. Your confidentiality and anonymity will be protected through the use of pseudonyms and alteration of any identifying information. If you experience distress as a result of discussing this topic, a list of counselling referrals will be provided to you.

By signing your name below, you agree that you have an understanding of

i. the purpose and nature of the study
ii. the expected benefits
iii. the time commitment
iv. the potential risks
v. the identity of the researchers
vi. how the information will be used
vii. the right to give or withhold consent for participation
viii. the right to withdraw at any time during the process
ix. how confidentiality and anonymity will be maintained

and that you give your informed consent to participate in the study.

_____ _____

Date Name of Participant

_____

Signature of Participant

_____

Signature of Researcher

Informed Consent Form for Parents/Legal Guardians

Your child is being asked to participate in a research study entitled "The Counselling Experiences of Suicidal Adolescents" being carried out by Agatha Beschell under the supervision of Dr. Robin Everall at the Department of Educational Psychology at the University of Alberta. Verbal and written descriptions of the study have been provided to you. If you have any questions or concerns, please feel free to address them at any time.

In an interview, your child will be asked to discuss his/her experience of being suicidal and his/her experience of the counselling which he/she received in relation to being suicidal. This is a voluntary project, therefore, you and/or your child have the right to withdraw your participation at any time without penalty. Your and your child's confidentiality and anonymity will be protected through the use of pseudonyms and alteration of any identifying information. If you or your child experience distress as a result of his/her discussing this topic, counselling referrals will be provided to you.

By signing your name below, you agree that you have an understanding of

i. the purpose and nature of the study
ii. the expected benefits
iii. the time commitment
iv. the potential risks
v. the identity of the researchers
vi. how the information will be used
vii. the right to give or withhold consent for participation
viii. the right to withdraw at any time during the process
ix. how confidentiality and anonymity will be maintained

and that you give your informed consent for your child to participate in the study.

_____ _____

Date Name of Child Participant

_____

Signature of Parent(s)/Legal Guardian

_____

Signature of Researcher

Assent Form for Participants

You are being asked to participate in a research study called "The Counselling Experiences of Suicidal Adolescents" being done by Agatha Beschell under the supervision of Dr. Robin Everall at the Department of Educational Psychology at the University of Alberta. If you have any questions, please ask them at any time.

You will be asked to talk about your experiences of being suicidal and the counselling you received. This is a voluntary project. You have the right to withdraw at any time without penalty. Your name and identity will be protected through the use of false names, and any information that could identify you will be changed. If you feel upset as a result of talking about these topics, counselling referrals will be given to you.

By signing your name below, you agree that you understand

i. the purpose and nature of the study
ii. the expected benefits
iii. the time commitment
iv. the potential risks
v. the identity of the researchers
vi. how the information will be used
vii. the right to give or withhold consent for participation
viii. the right to withdraw at any time during the process
ix. how confidentiality and anonymity will be maintained

and that you give your assent to participate in the study.

_____ _____

Date Name of Participant

_____

Signature of Participant

_____

Signature of Researcher

APPENDIX C: INTERVIEW GUIDE

Main questions

What was your experience of counselling after you were suicidal?

What was important about that counselling experience?

What was being in counselling like for you?

Supplementary questions

How long ago were you suicidal, and how did it start?

Did you have suicidal thoughts or suicidal behaviours or both?

How do you understand the fact that you were suicidal?

At what point did you go for counselling?

How long did the counselling last?

Whose idea was it that you go for counselling, and did you agree?

How did you feel about going for counselling?

What type of mental health professional provided the counselling?

Overall, how helpful was the counselling for you?

What was or was not helpful about the counselling?

Do you see your counselling experience differently today than you did then? How?

What advice about counselling do you have for suicidal teens?

What advice do you have for counsellors working with suicidal teens?

APPENDIX D: EXAMPLE OF TRAIL OF INTERPRETIVE DECISIONS

The following table shows a sample of the interpretive decisions made based on an excerpt of Matt's interview and integration of the findings across participant cases.

1. Original interview	He [counsellor] was, like, doing mass production there: we were all wearing the same [school] uniform, well, we were all seeing the same psychologist, and it was all the same thing. … We were all getting the same treatment, like, me being suicidal, the other one being beat up by his parents, and the other one had no self-esteem, we were all getting the same thing. … He was putting me in a big melting pot with all teenagers. Well, I wasn't all teenagers. (Matt)
2. Generation of initial themes	Feeling treated like a generic client/adolescent Recognizing myself as a unique individual
3. Identification of similar or related themes in other participants' accounts	Perceiving a lack of flexibility/originality in counselling (Haven) Assessing counselling method as juvenile (Haven) Not getting to do what I wanted to do in counselling (Simone) Feeling that I was treated like a child (Simone) Not utilizing preferred ways of emotional expression (Tina)
4. Recognition and naming of common themes across cases	Feeling that counselling did not cater to my unique needs (Feeling pigeonholed) Feeling that counselling was not appropriate to my age (Feeling disregarded)
5. Induction and naming of overall theme	Feeling unattended to as an individual

APPENDIX E: THEMATIC ANALYSIS RESULTS IN TABULAR FORM

Themes	Subthemes
1. Appreciating Counsellor Openness	Valuing counsellor attentiveness
	Valuing counsellor respectfulness
	Valuing counsellor genuineness
2. Needing Direction	Needing delineation of goals
	Needing guidance of session topics
3. Feeling Unattended to as an Individual	Feeling pigeonholed
	Feeling disregarded
4. Yearning for a Relational Climate	Wanting a counsellor attuned to adolescent culture
	Wanting a suitable physical environment
5. Wishing that Counsellors Would "Reroute" the Topic of Suicidality	